

03728

## CERTIFICATE OF DEATH

03716

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				e. STREET ADDRESS <u>4412 Butterworth Pl.</u>			
3. NAME OF DECEASED (Type or print) <u>Naama Allen</u>				4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/11/1917</u>	9. AGE (In years last birthday) <u>55</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Master</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edgar Allen</u>				14. MOTHER'S MAIDEN NAME <u>Virginia</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Edward L. Allen</u> Address <u>3930 -</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO <u>Acute Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>Essential Hypertension</u>							
PART II - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Essential Hypertension</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>p.m.</u> <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>June 1966</u> to <u>Mar 5, 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar 5, 1967</u> , and that death occurred <u>4:20 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Herbert Bauerfeld</u>				22b. DATE SIGNED <u>3/5/67</u>		22c. PHYSICIAN'S NAME (Type) <u>E. Herbert Bauerfeld</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>3-8-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Nat'l. Memorial Park</u>	
23d. LOCATION (City or Town) (County) (State) <u>Falls Church, Va.</u>				24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>9</u> 1967	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				25c. ADDRESS <u>5130 Wisc. Ave. N.W. Wash. D.C.</u>			

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03723

## CERTIFICATE OF DEATH

03717

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>18 days</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>HAYIE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mocksville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS <u>843 N. Main St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Jennie Anderson Anderson</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>25</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-75</u>	9. AGE (In years lost birthday) <u>91</u> yrs.	10. IF UNDER 1 YEAR Months <u>85</u> Days <u>19</u> Hours <u>67</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Julia Blackwell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>243-74-5377</u>		17. INFORMANT <u>Washington Sanitarium records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Vaper GI Bleeding</u> DUE TO (c) <u>Gastric ulcer</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>4.6 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>3-8</u> , 19 <u>67</u> , to <u>3-25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-25</u> , 19 <u>67</u> , and that death occurred at <u>10:30 AM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>R. H. Sandstrom</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. H. Sandstrom M.D.</u>		22d. ADDRESS <u>7701 Carroll Ave, Takoma Park, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/29/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Cemetery</u>	23d. LOCATION (City, or Town) (County) (State) <u>Mocksville Hayie No. Carol</u>		
24. FUNERAL DIRECTOR <u>Walter Walters</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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RECEIVED

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*[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]*



03724

CERTIFICATE OF DEATH

03718

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>WASH D.C.</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRINGS</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>1018 8th St. N.E.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>OTHELLO C. ANDERSON</u>		4. DATE OF DEATH Month Day Year <u>MAR. 20 19 67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/31/10</u>
9. AGE (In years last birthday) <u>56 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing Ass't.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Clark Cty, Ga.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT H. ANDERSON SR.</u>		14. MOTHER'S MAIDEN NAME <u>MAGGIE THURMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>258-05-6223</u>	
17. INFORMANT <u>JANICE ANDERSON DODGES - RICHMOND, VA.</u>		Address <u>2030 REYMET RD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>E. Coli Septicemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Lymphatic Leukemia</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1944</u> <u>4 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 65</u> , 19 <u>65</u> , to <u>3/20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/16</u> , 19 <u>67</u> , and that death occurred at <u>11:25 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Leonard Hood</u>		22b. DATE SIGNED <u>3/21/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-25-67</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Mem</u>		23d. LOCATION (City or Town) (County) (State) <u>Sutland Md.</u>	
24. FUNERAL DIRECTOR <u>E. Murray mpr</u>		25a. REC'D BY REGISTRAR <u>MAR 23 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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UNITED STATES DEPARTMENT OF AGRICULTURE

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## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		157	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>				d. STREET ADDRESS <u>8003 Eastern Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arhontis</u> Middle <u>Angelo</u> Last <u>Angelo</u>				4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5-6-92</u>	9. AGE (In years last birthday) yrs. <u>74</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u> Hours <u>67</u> Min.		IF UNDER 24 HRS. Hours <u>67</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMP.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>415-16-1538A</u>		17. INFORMANT <u>JIMMY ANGELO</u>		Address <u>12006 BLUE HILL RD. S.S. MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Esophageal varices</u> DUE TO (b) <u>Portal cirrhosis</u> (c) <u>Heart Hepatic failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/1</u> , 19 <u>67</u> , to <u>3/4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/3</u> , 19 <u>67</u> , and that death occurred at <u>5:55 A.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>William Falk Marcus</u> M.D.				22b. DATE SIGNED <u>3/4/67</u>		22c. PHYSICIAN'S NAME (Type) <u>William Falk Marcus</u>	
22d. ADDRESS <u>Holy Cross Hosp. S.S. MD.</u>				22e. REGISTRAR <u>Charles Judge</u>		22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7 MAR. 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CENWOOD CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON DC.</u>	
24. FUNERAL DIRECTOR <u>RINALDI FUNERAL HOME WASH. D.C.</u>				25a. REGD BY REGISTRAR <u>MAR 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #G387 1.7/67

03726

CERTIFICATE OF DEATH

03720

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>26 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLENWOOD</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>HICKORY HILL FARM, Rt. #97</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DONNIE</b>		First <b>DEVADA</b> Middle <b>ARMS</b>		4. DATE OF DEATH Month <b>3</b> Day <b>29</b> Year <b>67</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-3-03/04</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>BOYD JACKSON</b>			
14. MOTHER'S MAIDEN NAME <b>MARGARET LOWE</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>MEDICAL RECORDS</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphosarcoma</b> 2001 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 yr 1</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour "a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from <b>Sept</b> , 19 <b>66</b> to <b>3/29</b> , 19 <b>67</b> , that (H) (we) last saw the deceased alive on <b>3/29</b> 19 <b>67</b> , and that death occurred at <b>3:25 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>A. F. Woodward</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/30/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. F. WOODWARD, M. D.</b>				22d. ADDRESS <b>115 N. VAN BUREN ST., ROCKVILLE, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-1-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crest Lawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Alpha Heights, Md.</b>	
24. FUNERAL DIRECTOR <b>Willie H. Hight</b>				25a. REC'D BY REGISTRAR DATE <b>APR 4 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>	

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03727

## CERTIFICATE OF DEATH

03721

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>—</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DISTRICT OF Columbia</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>POTOMAC VALLEY NURSING HOME</u>		d. STREET ADDRESS <u>4201 MASS. AVE</u>	
3. NAME OF DECEASED (Type or print) <u>SHIRLEY S ASHTON</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-22-80</u>
9. AGE (In years last birthday) <u>87</u> yrs		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Civil Service U.S. Govt</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>KING GEO. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Charles Henry Ashton</u>		14. MOTHER'S MAIDEN NAME <u>Ida B. Welch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>— — —</u>	
17. INFORMANT <u>Betty P. Ashton, - See Item No. 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary Edema</u> DUE TO <u>—</u> (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>—</u> (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>5 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Fibillation; Periodic Complete Heart Block</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 20, 1966</u> , to <u>March 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 5, 1967</u> , and that death occurred at <u>11:24 A.M.</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Dr. C.R. Gruver</u>		22b. DATE SIGNED <u>3/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. C.R. Gruver</u>		22d. ADDRESS <u>915 19th St NW Wash. DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>3-10-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Episcopal</u>		23d. LOCATION (City or Town) (County) (State) <u>King George, Va.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W., Wash. DC</u>		25a. REC'D BY REGISTRAR <u>MAR 13 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

03728

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03722

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darnestown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darnestown</u>	
c. LENGTH OF STAY IN 1b <u>15-1</u>		d. STREET ADDRESS <u>12916 Scarlet Oak Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12916 Scarlet Oak Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Steven</u> Middle <u>James</u> Last <u>Bailey</u>		4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 11, 1956</u>
9. AGE (In years last birthday) <u>10 yrs.</u>		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Walter M. Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Phyllis Ann Coulter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Walter M. Bailey - father - item #2</u>		Address <u>-----</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia -</u> <u>1001</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Compression of chest.</u> DUE TO (c) <u>-----</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall in deep hole in ground squeezing chest.</u>	
20c. TIME OF INJURY Month, Day, Year <u>3:15 p.m. 3/11/1965</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hole in ground</u>		20f. (City or town) (County) (State) <u>Darnestown Mont. Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John D. Ball</u>		22. DATE SIGNED <u>3/2/67</u>	
NAME (Type) <u>John D. Ball</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <u>-----</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Darnestown</u>	23d. LOCATION (City, town or county) (State) <u>Darnestown, Maryland</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>		ADDRESS <u>1331 Rockville Pike</u> <u>Rockville, Maryland</u>	
25a. REC'D BY REGISTRAR <u>MAR 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



03723

## CERTIFICATE OF DEATH

03723

1. PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>20 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Seaboard</u>		d STREET ADDRESS <u>1520 Chillum Road</u>	
3. NAME OF DECEASED (Type or print) First <u>ETHEL</u> Middle <u>M.</u> Last <u>BARDUCHE</u>		4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-26-16</u>
9 AGE (In years last birthday) <u>50</u> yrs.		10 IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>		11b KIND OF BUSINESS OR INDUSTRY <u>Mary Dept. Wisconsin</u>	
11c BIRTHPLACE (County & State, or foreign country) <u>USA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Joseph P. Barduche</u>		14. MOTHER'S MAIDEN NAME <u>Mary Collins</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>399-07-1299</u>	
17. INFORMANT <u>Mrs Joseph Barduch</u>		Address <u>Totter Road, FLA.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia</u> 1500 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>metastatic carcinoma colon</u> DUE TO (c) <u>surgical resection obstructed Ca colon</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-4-67</u> , 19 <u>67</u> , to <u>3-29-67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-29</u> , 19 <u>67</u> , and that death occurred at <u>3:30 P</u> M, from causes on and on the date stated above.			
22a SIGNATURE <u>John C. Robben</u>		22b. DATE SIGNED <u>3-29-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John C. Robben MD</u>		22d. ADDRESS <u>10400 CONNETT AVE KENSINGTON MD</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>3/31/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>ALLOUPE</u>	23d LOCATION (City or Town) (County) (State) <u>GREEN BAY WISC.</u>
24 FUNERAL DIRECTOR <u>Will Chambers Co Inc. GEORGETOWN</u>		25a REC'D BY REGISTRAR <u>MAR 31 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03730

CERTIFICATE OF DEATH

03724

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN b. <b>5 min.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		e. STREET ADDRESS <b>3618 Gleneagles Dr. Apt. 7-2E</b>	
3. NAME OF DECEASED (Type or print) <b>Adelaide</b> <sup>First</sup> <b>Charlotte</b> <sup>Middle</sup> <b>Barker</b> <sup>Last</sup>		4. DATE OF DEATH Month <b>Mar.</b> Day <b>10</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-1-39</b>
9. AGE (In years last birthday) <b>27</b> yrs		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b> Hours <b>10</b> Min <b>0</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Social Worker</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward H. Barker</b>		14. MOTHER'S MAIDEN NAME <b>Emily S. Gregory</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>579-22-9028A</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> DUE TO (b) <b>Arteriosclerotic - Coronary Heart Disease</b> DUE TO (c) <b>Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Aug</b> , 19 <b>66</b> , to <b>March 10</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>March 1</b> , 19 <b>67</b> , and that death occurred at <b>6:40 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Ruth A. Yates</b>		22b. DATE SIGNED <b>3/10/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. R.A. Yates</b>		22d. ADDRESS <b>OLNEY, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	23b. DATE THEREOF <b>3/13/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CREMATORY</b>	23d. LOCATION (City or Town) (County) (State) <b>SUITLAND, MD.</b>
24. FUNERAL DIRECTOR <b>JOS BAWLER'S SONS, 5130 WIS. AVE. NW, WASH, D.C.</b>		25a. REC'D BY REGISTRAR <b>MAR 14 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judet</b>



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03731

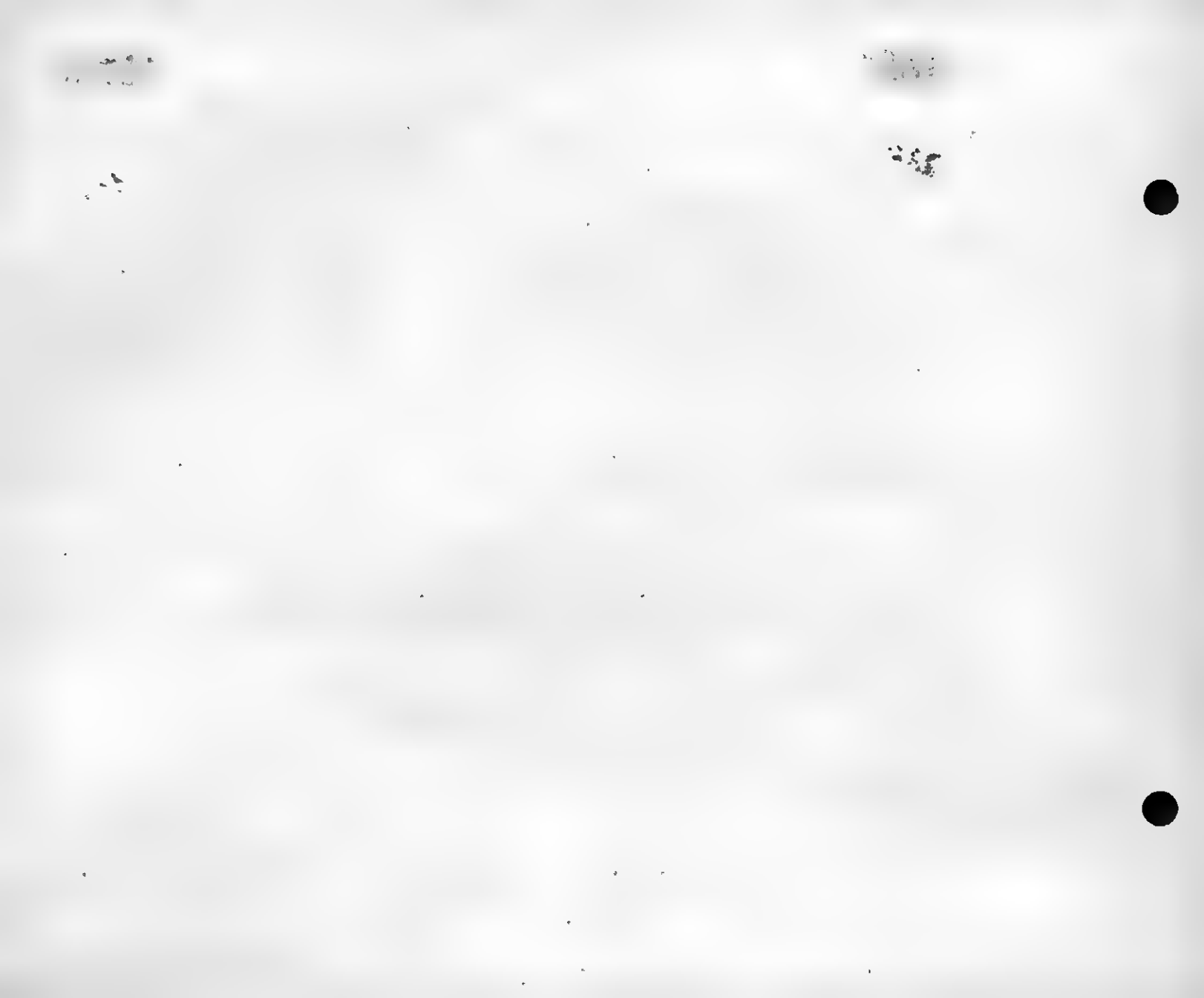
## CERTIFICATE OF DEATH

03725

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN lb <u>12 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u> <u>16-2</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Md. 20014</u>				d. STREET ADDRESS <u>19 M Ridge Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Leonard A. (Initial only) Baron</u>				4. DATE OF DEATH Month Day Year <u>March 20, 19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 December 1919</u> <u>47</u>		9. AGE (In years last birthday) yrs <u>47</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Economist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Federal Government</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Baron</u>				14. MOTHER'S MAIDEN NAME <u>Ann Bluman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>114-12-2316</u>		17. INFORMANT <u>The Medical Record</u> <u>The Clinical Center, Bethesda, Maryland 20014</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> <u>1761</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Open biopsy (R) Femur</u> DUE TO (c) <u>Chondrosarcoma (R) Femur head</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>3 Weeks</u> <u>7 Months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>he</del> (this hospital) attended the deceased from <u>March 8</u> , 19 <u>67</u> , to <u>March 20</u> , 19 <u>67</u> , that <del>he</del> (we) last saw the deceased alive on <u>March 20</u> , 19 <u>67</u> , and that death occurred at <u>5:30</u> <u>PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>John Dae Harrah</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>21 March 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>John Dae Harrah, MD.</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/21/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial Garden Falls Church</u>		23d. LOCATION (City or Town) (County) (State) <u>Va.</u>	
24. FUNERAL DIRECTOR <u>Donald M. Stein</u> <u>Hebrew Memorial Funeral Home</u>				ADDRESS <u>232 Carroll</u> <u>Wash. DC 20012</u>		25a. REC'D BY REGISTRAR <u>MAR 23 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

CLEARER WITH MEDICAL DEPUTY EXAMINER

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03732

CERTIFICATE OF DEATH

03726

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE, MD</b>		c. LENGTH OF STAY IN TB <b>2 HOURS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SANITARY HOSPITAL</b>		d. STREET ADDRESS <b>2119 Guilford Rd</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ALEXANDER (NONE) BARONI-SE</b>		4 DATE OF DEATH Month Day Year <b>3 24 1967</b>	
5. SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-23-23</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mgr. NEW 44 RESTAURANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BEAUNTON, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>	
13. FATHER'S NAME <b>Alexander Baroni</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Ragusa</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NAVY WW2</b>		16. SOCIAL SECURITY NO <b>UNAVAILABLE</b>	
17. INFORMANT <b>MRS IRENE V. BARONI</b>		Address <b>2119 Guilford Rd. HYATTS, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia</b> 2041 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Myelogenous leukemia (blast)</b> DUE TO (c) <b>crisis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11</b> , 19 <b>65</b> to <b>3-24</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3-23</b> 19 <b>67</b> , and that death occurred at <b>1 P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Gilbert B. Cushe</b>		22b. DATE SIGNED <b>3-24-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Sokoma Park, Md.</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>March 27, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Colmar Manor, Pro Geo Md.</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>MAR 28 1967</b>	
ADDRESS <b>Hyattsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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03733

## CERTIFICATE OF DEATH

03728

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
c. LENGTH OF STAY <u>16</u> weeks			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLT CROSS HOSPITAL</u>		d. STREET ADDRESS <u>9116 GEORGIA AVE</u>	
3 NAME OF DECEASED (Type or print) First <u>RALEIGH</u> Middle <u>R.</u> Last <u>BAUM</u>		4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUC.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-12-89</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Treasury</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Clark County, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Baum</u>		14. MOTHER'S MAIDEN NAME <u>Alice Lowry</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>220-40-4852</u>	
17. INFORMANT <u>Mrs. Ella Mae Goddard</u>		Address <u>3610 St Barnabas Rd Silver Hill, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, lobular, bilateral</u> DUE TO <u>known</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Emphysema, chronic, severe</u> DUE TO <u>known</u> (c) <u>Pulmonary fibrosis</u> DUE TO <u>2 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>known</u> <u>2 years</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>1</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 25</u> , 19 <u>54</u> , to <u>March 16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 16</u> , 19 <u>67</u> , and that death occurred at <u>7:45</u> P.M., from causes on and on the date stated above.			
22a. SIGNATURE <u>Claron H. Traum</u>		22b. DATE SIGNED <u>March 17 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Aaron H. Traum</u>		22d. ADDRESS <u>8237 Georgia Ave - Silver Spring, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar 20, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>C. Glen Carter &amp; Son, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) A  
6M 1/67

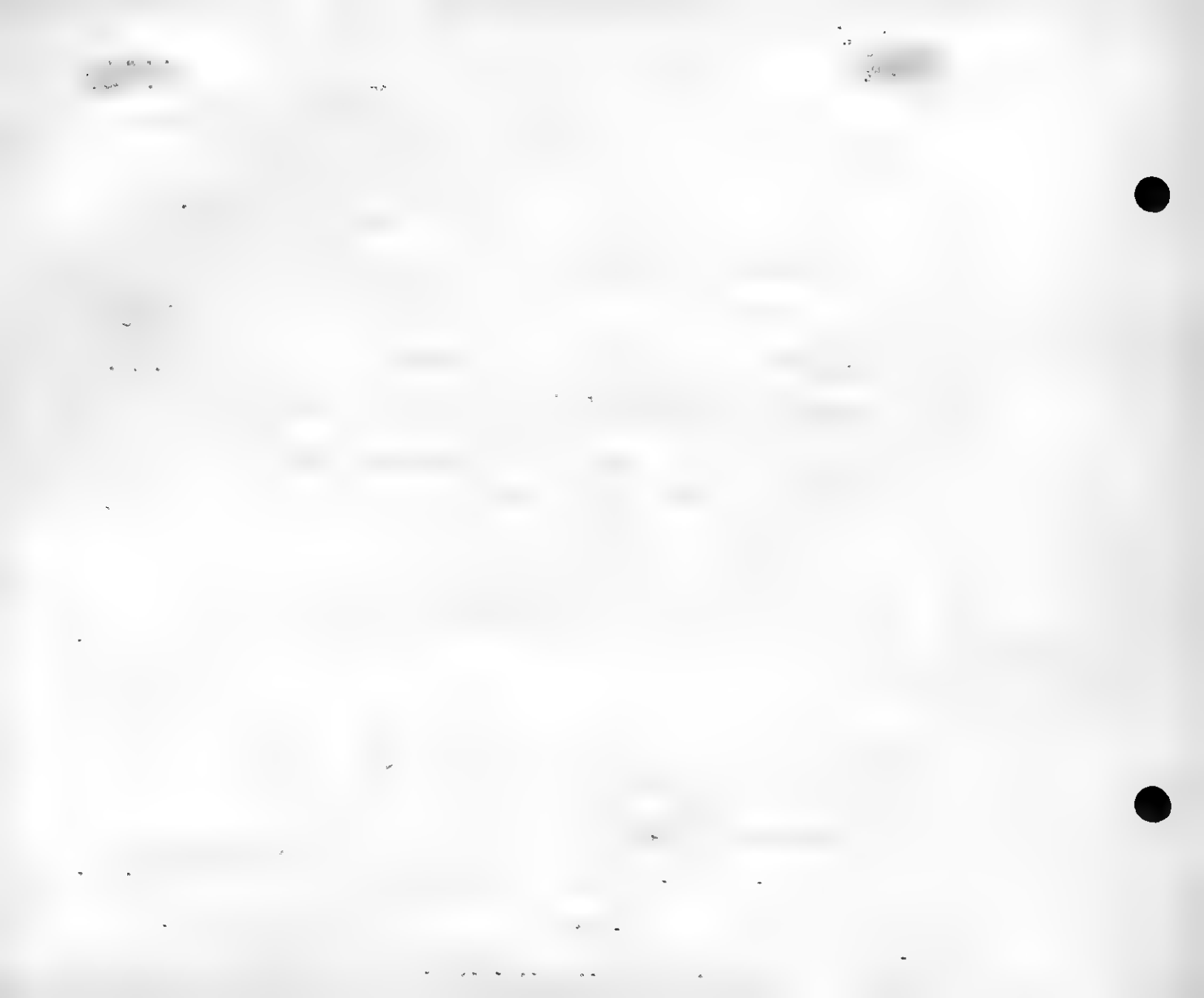
**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**03734**

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**03729**

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince George's</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c LENGTH OF STAY IN 1b <u>Do A</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <u>Holy Cross Hospital</u>				d STREET ADDRESS <u>12901 Forest View Dr. St.</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Heather Suzanne Baumgardt</u>				4 DATE OF DEATH Month Day Year <u>March 3 1967</u>			
5 SEX <u>Fe-</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12/13/66</u>	9 AGE (In years lost birthday) yrs <u>8.25</u>	IF UNDER 1 YEAR Months Days <u>8 25</u>	IF UNDER 24 HRS Hours Mins <u></u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b KIND OF BUSINESS OR INDUSTRY <u></u>		11 BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Hans Edward Baumgardt Jr</u>				14 MOTHER'S MAIDEN NAME <u>Gertrude Eyre</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>None</u>		17 INFORMANT Address <u>Hans Baumgardt Same as #2</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>491X Broncho Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour o.m. pm <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>		EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u>		22. DATE SIGNED <u>3/4/67</u>		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>3/6/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>St. Marks</u>		23d LOCATION (City or Town) (County) (State) <u>Highland, Md.</u>	
24 FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc. 8434 Ga., Ave., S.S., Md.</u>				25a REC'D BY REGISTRAR <u>MAR 8 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



03735

## CERTIFICATE OF DEATH

03730

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>151</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1215 Edmonston Drive</u>		d. STREET ADDRESS <u>1215 Edmonston Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Arturs</u> <u>Baumhammers</u>		4 DATE OF DEATH Month Day Year <u>March</u> <u>29</u> <u>1967</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Jan. 6, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Red Cross</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) yrs <u>74</u>
11 BIRTHPLACE (County & State or foreign country) <u>Latvia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Alberts Baumhammers</u>		14 MOTHER'S MAIDEN NAME <u>Wilhelmina Tiesenbergs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Margrieta A. Baumhammers - wife - it</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured aneurysm, right internal carotid artery</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>7 mos</u> <u>7 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April 17</u> , 1965, to <u>Mar. 29</u> , 1967, that (I) (we) last saw the deceased alive on <u>Mar. 25</u> , 1967, and that death occurred at <u>1:35 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>Mar. 29, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>William J. Cohen</u>		22d. ADDRESS <u>1215 Edmonston Drive, Rockville, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/1/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>
23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>			
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>MAR 31 1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
03736		CERTIFICATE OF DEATH				03731				
Item #11 Film #3-7 5/1/67 pc										
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase					c. LENGTH OF STAY IN 1b 2 mo. 19 days					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BETHESDA SILVER SPRING NURSING HOME					d. STREET ADDRESS Kensington, Md.					
3. NAME OF DECEASED (Type or print) First Middle Last JULIA S. BEAN					4. DATE OF DEATH Month Day Year March 18 19 67					
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 9, 1889		9. AGE (In years last birthday) 77 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Govt.		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (County & State, or foreign country) Missouri Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Truman I. Milstead					14. MOTHER'S MAIDEN NAME Annie M. Milstead					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Doris C. Quigley			
					Address 4515 Avondale Bethesda, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastases Carcinoma</i> 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Benign Carcinoma</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 6 Mos. 9 Mos.		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1960, 19 to March 18, 19 67, that (I) (we) last saw the deceased alive on May 16, 19 67, and that death occurred at 2:15 P.M. from the causes and on the date stated above.										
22a. SIGNATURE <i>George Sharpe</i>					22b. DATE SIGNED March 18, 1967					
22c. PHYSICIAN'S NAME (Type) GEORGE SHARPE					22d. ADDRESS 10400 Conn. Ave. Kensington, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE THEREOF March 21, 67		23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery		23d. LOCATION (City, town or county) (State) Gaithersburg, Maryland			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY					ADDRESS BETHESDA, MARYLAND		25a. REC'D BY REGISTRAR MAR 28 1967		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div> <div>Item 21 1m 307 4-7-67 am</div> <div> <div>03737</div> <div>03732</div> </div> </div> <div> <div> <div>03737</div> <div>03732</div> </div> <div> <div>03737</div> <div>03732</div> </div> </div>												
1. PLACE OF DEATH o COUNTY <b>Montgomery</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Connecticut</b> b. COUNTY						
b. CITY OR TOWN (f outside corporate limits write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY in lb <b>27 Days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westport</b>						
d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>						d. STREET ADDRESS <b>130 Hillandale Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Herbert</b> Middle <b>Simon</b> Last <b>Beardsley</b>			4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>19 67</b>			5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>29 August 1906</b>			9. AGE (In years last birthday) <b>60</b> yrs			10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.			11. IF UNDER 24 HRS Days <b>1</b> Hours <b>1</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Connecticut</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Frank Beardsley</b>						14. MOTHER'S MAIDEN NAME <b>Pauline Bohl</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>090-01-4723</b>		17. INFORMANT <b>The Medical Records, The Clinical Center, Bethesda, Maryland 20014</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b> <b>2043</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Acute Myelogenous Leukemia</b> DUE TO (c) <b>1 month</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that <del>XX</del> (this hospital) attended the deceased from <b>6 February 19 67</b> , to <b>5 March 19 67</b> , that <del>XX</del> (we) last saw the deceased alive on <b>5 March 19 67</b> , and that death occurred at <b>10:00 A.M.</b> , from causes and on the date stated above.												
22a. SIGNATURE <b>Dr. Charles L. Vogel</b> M.D.						22b. DATE SIGNED <b>5 March 1967</b>			22c. PHYSICIAN'S NAME (Type) <b>Charles L. Vogel, M.D.</b>			
22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>												
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>				23b. DATE THEREOF <b>3/6/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CREMATORY</b>				23d. LOCATION (City or Town) (County) (State) <b>SUITLAND, MD.</b>		
24. FUNERAL DIRECTOR <b>JOS. GAWLER'S SONS, 5130 N.W. AVE., N.W., WASH., D.C.</b>						25a. REC'D BY REGISTRAR <b>MAR 9 1967</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

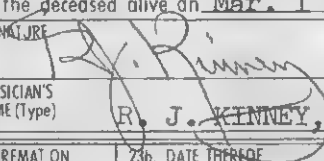

VR A15 (4)  
25M 1/67

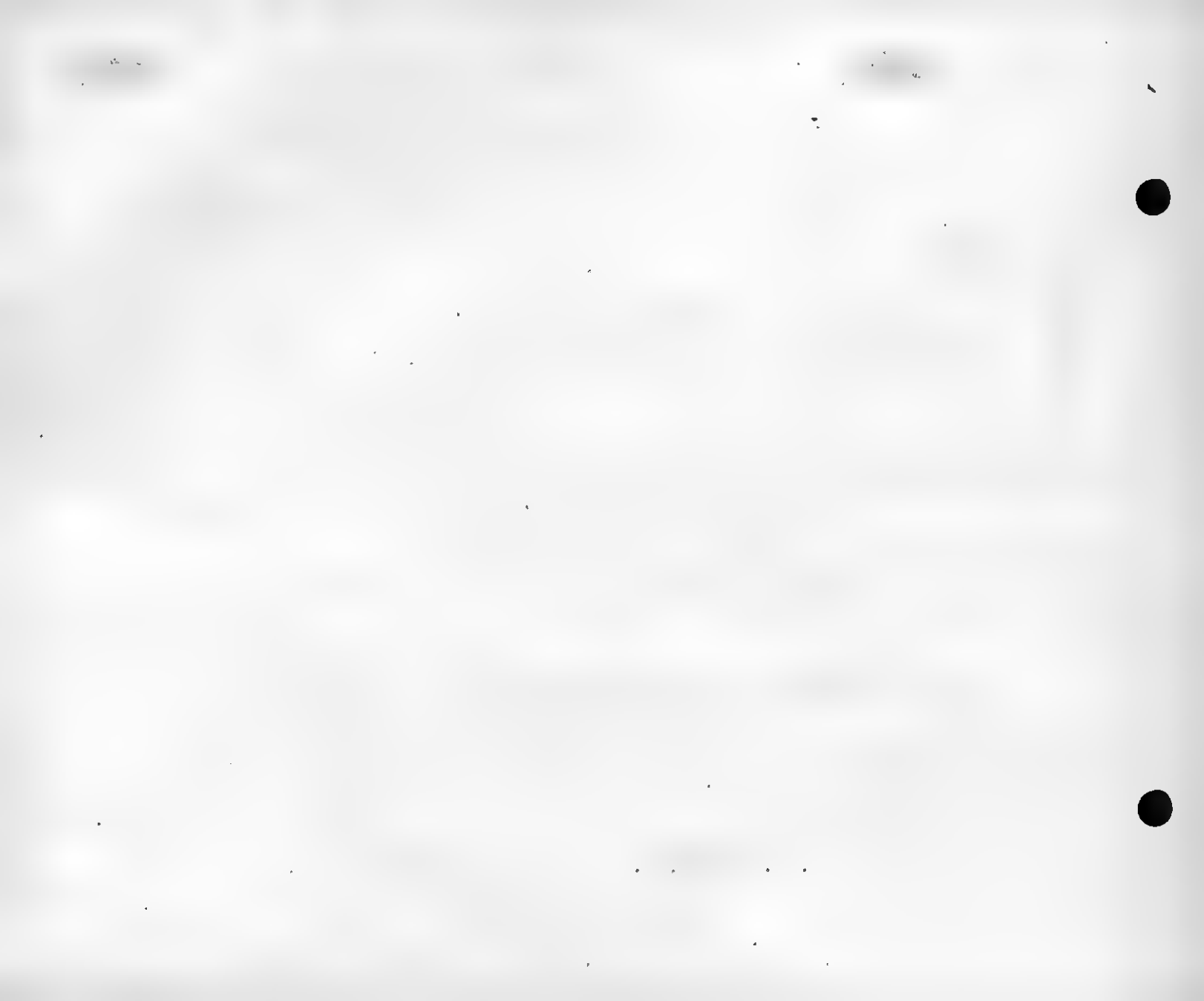
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03738

CERTIFICATE OF DEATH

03733

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c LENGTH OF STAY IN lb <b>6 days</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>6004 Marquette Terrace</b>	
3 NAME OF DECEASED (Type or print) <b>Anne E. BELLAR</b>		4 DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>Cauc</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Sept. 18, 1896</b>
9. AGE (In years last birthday) <b>70</b> yrs		10. BIRTHPLACE (County & State, or foreign country) <b>Cook, Illinois</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Michael Elenz</b>		14. MOTHER'S MAIDEN NAME <b>Marie Jacobs</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>271-18-7915</b>	
17 INFORMANT <b>Terrace</b>		Address <b>Bethesda, Md.</b> <b>CDR Fred James Bellar, USN, 6004 Marquette</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Myocardial Infarction with congestive heart failure</b> DUE TO failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21 I certify that <del>(1)</del> (this hospital) attended the deceased from <b>Feb. 23</b> , 19 <b>67</b> , to <b>Mar. 1</b> , 19 <b>67</b> that <del>(1)</del> (we) lost saw the deceased alive on <b>Mar. 1</b> , 19 <b>67</b> , and that death occurred at <b>850AM</b> , from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED <b>2 Mar. 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. J. KINNEY, M.D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>	23d. LOCATION (City or Town) _____ (County) _____ (State) <b>Montgomery, Ohio</b>
24 FUNERAL DIRECTOR <b>Robert A. Pumphrey</b> ADDRESS <b>Funeral Home, 7557 Wisconsin Ave., Bethesda, Md.</b>		25a. REC'D BY REGISTRAR <b>DAVID R 8 1967</b>	
		25b. REGISTRAR'S SIGNATURE 	



03739

## CERTIFICATE OF DEATH

03734

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN lb <u>2 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		1-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kandolph Heale Nursing Home</u>				d. STREET ADDRESS <u>5702 Darneston Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Paul</u> Last <u>Benson</u>				4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>9-11-1901</u>	
9. AGE (In years last birthday) <u>65 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Purchasing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>solider home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>R. J. Benson</u>			
14. MOTHER'S MARDEN NAME <u>Elizabeth Murphy</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>578-07-4586</u>			
16. SOCIAL SECURITY NO. <u>578-07-4586</u>				17. INFORMANT <u>MRS John S Mathews - Address 5702 Darneston Rd - Bethesda, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatic Carcinoma</u>						INTERVAL BETWEEN ONSET AND DEATH <u>None</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>October 1964</u> to <u>3/25/1967</u> , that (I) (we) last saw the deceased alive on <u>3/24/1967</u> , and that death occurred at <u>11:30 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Robert U. Macon</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>3/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert U. Macon, M. D.</u>				22d. ADDRESS <u>809 Viers Mill Rd Rockville, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 28, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hyattstown Meth. Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hyattstown, Maryland</u>	
24. FUNERAL DIRECTOR <u>Donald M. Etchison &amp; Son, Frederick, Maryland</u>				25a. REC'D BY REGISTRAR <u>DATE 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MONTGOMERY STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				03735					
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San + Hospital</u>				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1224 Dale Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3 NAME OF DECEASED (Type or print) <u>William C. Betson</u>				4 DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1967</u>									
5 SEX <u>male</u>		6 COLOR OR RACE <u>white</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>12-7-16</u>		9 AGE (in years) <u>50</u>		10 UNDER 1 YEAR IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Building Supt</u>				10b KIND OF BUSINESS OR INDUSTRY <u>Building</u>				11 BIRTHPLACE (State or foreign country) <u>Frederick, Md.</u>				12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>Harry C. Betson</u>				14 MOTHER'S MAIDEN NAME <u>Sally W. Fields</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW2 (Army)</u>				16 SOCIAL SECURITY NO <u>WW2 (Army)</u>				17 INFORMANT <u>Frances G. Warfield</u> Address <u>Dickerson, Md.</u>					
18 CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation due to nasal hemorrhage</u> DUE TO (b) <u>with aspiration of blood</u> DUE TO (c) <u>lost.</u>										INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased fell &amp; fractured nose which bled</u>									
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>9:00</u> <u>3-19</u> <u>1967</u>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f (City or town) <u>Silver Spring</u> (County) <u>Montg.</u> (State) <u>Md.</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.				22. DATE SIGNED <u>3/19/1967</u>									
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>				23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b DATE THEREOF <u>3/22/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>			
24 FUNERAL DIRECTOR <u>Constance C. Hilton</u>				ADDRESS <u>Barnesville Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

1000 1000 1000

1000 1000 1000



FOR STATE  
HEALTH DEPT.

03741

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03736

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased resided, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN It <u>1 1/2 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>WASH-SAN-HOSPITAL</u>				d. STREET ADDRESS <u>1056 RUATAN ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>(MR.) EDWARD PRESTON BIRKHEAD</u>				4 DATE OF DEATH Month <u>3</u> - Day <u>24</u> Year <u>1967</u>			
5 SEX <u>MALE</u>		6 COLOR OR RACE <u>WHITE</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>3-4-64</u>	
9 AGE (In years lost birthday) yrs. <u>3</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11 BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>				12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13 FATHER'S NAME <u>EDWARD PRESTON BIRKHEAD, SR.</u>				14 MOTHER'S MAIDEN NAME <u>Sandra Harris</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16 SOCIAL SECURITY NO. <u>None</u>		17 INFORMANT <u>Edward Edward Birkhead</u>		Address <u>1056 Ruatan Street Silver Spring, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute, severe, viral encephalitis and</u> DUE TO (b) <u>markedly severe mesenteric adenitis</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>BELDEN R. REAP</u>		M.D. <u>BELDEN R. REAP M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street City-Town or county) <u>  </u>		22. DATE SIGNED <u>3/25/1967</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>Mar 28, 1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>				ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a REC'D BY REGISTRAR DATE <u>MAR 29 1967</u>	
				25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISM 5  
6M 1/66

<div> <div> <div>1</div> <div>ITEMS 18&amp;21 Film 388 5-9-60</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> </div> </div>											
<div>03742</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>03737</div>											
<div>1 PLACE OF DEATH</div> <div>a. COUNTY</div> <div>Montgomery</div> <div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Silver Spring, Md.</div> <div>c. LENGTH OF STAY IN 1b</div>						<div>2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)</div> <div>a. STATE</div> <div>Md.</div> <div>b. COUNTY</div> <div>Montgomery</div> <div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Takoma Park</div>					
<div>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</div> <div>Holy Cross Hospital</div>						<div>d. STREET ADDRESS</div> <div>7719 Eastern Ave.</div> <div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input type="checkbox"/></div>					
<div>3 NAME OF DECEASED</div> <div>(Type or print)</div> <div>First Middle Last</div> <div>Ralph Evans Bloom</div>						<div>4 DATE OF DEATH</div> <div>Month Day Year</div> <div>3 18 1967</div>					
<div>5 SEX</div> <div>M</div>		<div>6 COLOR OR RACE</div> <div>W</div>		<div>7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<div>8 DATE OF BIRTH</div> <div>2/7/09</div>		<div>9 AGE (In years last birthday) yrs</div> <div>58</div>		<div>IF UNDER 1 YEAR</div> <div>Months Days Hours Min</div>	
<div>10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)</div> <div>plasterer</div>				<div>10b. KIND OF BUSINESS OR INDUSTRY</div>		<div>11. BIRTHPLACE (State or foreign country)</div> <div>Norfolk, Va.</div>			<div>12. CITIZEN OF WHAT COUNTRY?</div> <div>US</div>		
<div>13. FATHER'S NAME</div> <div>Isaac D. Bloom</div>						<div>14. MOTHER'S MAIDEN NAME</div> <div>Doris Bloom/wife</div>					
<div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</div> <div>No</div>				<div>16. SOCIAL SECURITY NO</div> <div>214-01-0976</div>		<div>17. INFORMANT</div> <div>Doris Bloom/wife</div> <div>Address</div>					
<div>18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>4a. IMMEDIATE CAUSE (a)</div> <div>Acute right coronary thrombosis</div> <div>DUE TO</div> <div>(b)</div> <div>Arteriosclerotic heart disease</div> <div>DUE TO</div> <div>(c)</div>										<div>INTERVAL BETWEEN ONSET AND DEATH</div>	
<div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div>											
<div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div>											
<div>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</div>				<div>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)</div>							
<div>20c. TIME OF INJURY Month, Day, Year</div> <div>Hour a.m. p.m.</div> <div>19</div>				<div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div>		<div>20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.)</div>		<div>20f. (City or town) (County) (State)</div>			
<div>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div>											
<div>ACTUAL SIGNATURE</div> <div>Belden R. Reap M.D.</div>						<div>CHIEF MEDICAL EXAMINER <input type="checkbox"/></div> <div>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></div> <div>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></div> <div>Address (Street, city, town, or county)</div>					
<div>EXAMINER'S NAME (Type)</div> <div>BELDEN R. REAP M.D.</div>						<div>22. DATE SIGNED</div> <div>3/19/1967</div>					
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div>				<div>23b. DATE THEREOF</div> <div>3/22-67</div>		<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Lorraine Park Cemetery</div>		<div>23d. LOCATION (City or town) (County) (State)</div> <div>Baltimore Md.</div>			
<div>24. FUNERAL DIRECTOR</div> <div>ADDRESS</div> <div>Frank W. Leaty, 814 W. 36th St., Balto., Md.</div>						<div>25a. REC'D BY REGISTRAR</div> <div>25b. REGISTRAR'S SIGNATURE</div> <div>MAR 22 1967</div>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03743

CERTIFICATE OF DEATH

03738

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN. &amp; HOSPITAL</u>		d. STREET ADDRESS <u>2418 North Capitol St.</u>	
3. NAME OF DECEASED (Type or print) <u>Evelyn C. Bodwell</u>		4. DATE OF DEATH Month <u>3</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-18-71</u>
9. AGE (In years lost birthday) <u>96</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Gonn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Clayton</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE PECK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>NIC</u> DUE TO <u>Bladder tumors (Ca) with obstruction of ureters</u> (b) <u>Probable kidney tumor on the left.</u> (c) <u>Involvement of kidneys with renal insufficiency and uremia</u> <u>M.ocardial insufficiency with congestive failure</u> <u>Mild diabetes mellitus ?</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/15/67</u> , 19 <u>67</u> , to <u>3/30/</u> , 1967, that (I) (we) last saw the deceased alive on <u>3/30/1967</u> , and that death occurred at <u>1:50 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Chas H W. Lohon</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Chas H W. Lohon</u>		22d. ADDRESS <u>7401 Blair Rd. N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/3/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>The S.H. Hines Company</u> <u>2901 14th St. N.W. Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>APR 4 1967</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	





03744

## CERTIFICATE OF DEATH

03739

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u> c. LENGTH OF STAY IN 1b <u>2 months - 5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John, Md.</u> d. STREET ADDRESS <u>7409 ARDEN RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>MARGARET ANN Bello</u>				4 DATE OF DEATH <u>MAR. 23, 1967</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 18, 1922</u>	9. AGE (In years last birthday) <u>44</u> yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MONTG. CO. BOARDING PATROL GUARD</u>		11. BIRTHPLACE (County & State or foreign country) <u>Washington, D.C.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MONTG. CO. BOARDING PATROL GUARD</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>PATROL GUARD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PATRICK KEADY</u>				14. MOTHER'S MAIDEN NAME <u>MAY WHITE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>Joseph Bello JR - 7409 ARDEN RD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>170X</u> DUE TO <u>Metastatic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>Breast - Bilateral</u> DUE TO (b) <u>Breast - Bilateral</u> DUE TO (c) <u>Breast - Bilateral</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 8, 1962</u> to <u>Mar. 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar. 21, 1967</u> , and that death occurred at <u>2:40 AM</u> , from causes on and on the date stated above.							
22a. SIGNATURE <u>Robert G. Brewer</u> M.D.				22b. DATE SIGNED <u>3-23-67</u>		22c. PHYSICIAN'S NAME (Type) <u>ROBERT G. BREWER</u>	
22d. ADDRESS <u>8505 Old Georgetown Rd. Bethesda, Md.</u>				22e. REC'D BY REGISTRAR <u>MAR 27 1967</u>			
22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>3-27-67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>			
23d. LOCATION (City or Town) <u>Suitland, Maryland</u>				23e. LOCATION (County) (State)			
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				25c. REGISTRAR'S SIGNATURE			



03745

## CERTIFICATE OF DEATH

03740

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home</u>		d. STREET ADDRESS <u>1237 JUDSON ROAD</u>	
3 NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Jane</u> Last <u>BORT</u>		4 DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>10-16-1912</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) <u>54</u> yrs
11 BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Alvin J. Hitchcock</u>		14. MOTHER'S MAIDEN NAME <u>Carrie L. Daum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>Husband</u> <u>Artemas R. Bort</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL BRONCHOPNEUMONIA</u> DUE TO (b) <u>METASTATIC CARCINOMA OF LIVER</u> DUE TO (c) <u>PRIMARY UNDETERMINED</u> 1062 Cond't ans, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>6 MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>MUSCULAR DYSTROPHY</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>MAR. 2, 1967</u> , to <u>MARCH 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>MARCH 6, 1967</u> , and that death occurred at <u>7:10 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert G. Angle</u>		22b. DATE SIGNED <u>MAR. 8, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT G. ANGLE</u>		22d. ADDRESS <u>5009 Del Ray Ave.</u> <u>Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-11-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 10 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



14

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03746

CERTIFICATE OF DEATH

03741

1 PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 33 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General		d. STREET ADDRESS 14207 Avery Rd.	
3 NAME OF DECEASED (Type or print) First Anna Middle Mae Last Boyd		4. DATE OF DEATH Month March Day 20 Year 67	
5 SEX Female	6 COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/6/25
9. AGE (In years lost birthday) 42 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stanley Gibbs		14. MOTHER'S MAIDEN NAME Johnsie Carol	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records, Olney, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause pending for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Secondary Anemia (c) Adenocarcinoma of Cervix with metastases		INTERVAL BETWEEN ONSET AND DEATH 1 yr 2 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 6/1/65 to 3/20/67, that (I) (we) last saw the deceased alive on March 20 19 67, and that death occurred at 6:30 p.m. from causes on and on the date stated above.			
22a. SIGNATURE Charles H. Ligon		22b. DATE SIGNED 3/20/67	
22c. PHYSICIAN'S NAME (Type) Charles H. Ligon		22d. ADDRESS Sandy Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Mar. 24 1967	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	23d. LOCATION (City or town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Robert F. Ligon, Baltimore, Md.		25a. REC'D BY REGISTRAR MAR 23 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03747

CERTIFICATE OF DEATH

03742

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>1</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>			c. LENGTH OF STAY IN 1b <b>78 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				d. STREET ADDRESS <b>8613 Irvington Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>John Douglas BRADBURY</b>				4. DATE OF DEATH Month Day Year <b>March 6 19 67</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 14, 1918</b>	
9. AGE (in years last birthday) yrs <b>48</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Brookline, Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Marine Corps</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>			
13. FATHER'S NAME <b>Royall Douglas Bradbury</b>				14. MOTHER'S MAIDEN NAME <b>Agatha Carney</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1940-1960</b>				16. SOCIAL SECURITY NO <b>142-18-0852</b>		17. INFORMANT <b>Bethesda, Maryland</b> <b>Mrs. Lillian Bradbury, 8613 Irvington Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laennec's Cirrhosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Bronchial pneumonia</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>16</b>		20f. (City or town) (County) (State) <b>16</b>	
21. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>Dec. 18</b> , 19 <b>67</b> , to <b>Mar. 6</b> , 19 <b>67</b> , that <del>(X)</del> (we) last saw the deceased alive on <b>Mar. 6</b> , 19 <b>67</b> , and that death occurred at <b>135A</b> M, from causes and on the date stated above							
22a. SIGNATURE <b>Elliott Perlin</b>				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Mar. 6, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Elliott Perlin, M. D.</b>				22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-9-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington Va.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler &amp; Sons</b> <b>5130 Wisconsin Ave., N.W., Washington, D.C.</b>				25a. RECD BY REGISTRAR <b>MAR 13 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03748

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03743

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		d. STREET ADDRESS <u>5400 Poole Hill Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward Leo Brady</u>		4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 12, 1887</u>
9. AGE (In years birthday) <u>79</u> yrs		10. UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Regatta Bank</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Brady</u>		14. MOTHER'S MAIDEN NAME <u>Anna Craven</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>579 12 7657</u>	
17. INFORMANT <u>Lottie McElaine (Sister)</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Inf. old + recent</u> DUE TO (b) <u>Coronary Atherosclerosis, severe</u> DUE TO (c) <u>yo -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		9. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball, M. D.</u>		ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>	
		DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL OR CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/23/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc. Washington, D. C.</u>		25a. RECD BY REGISTRAR <u>MAR 29 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>



03749

## CERTIFICATE OF DEATH

03744

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>112 Indian Spring Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Robert A Brecht</u>		4. DATE OF DEATH <u>3/24/67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/11/24</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bureau of U.S. Govt Eng.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles A. Brecht</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Plant</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes give year or dates of service) <u>57-60-0681</u>	
17. INFORMANT <u>Mary A. Sweeney</u>		Address <u>112 Indian Spring Drive Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> DUE TO (b) <u>Advanced Arterio-sclerotic Heart Disease</u> DUE TO (c) <u>Arterio-sclerosis</u>		INTERVA. BETWEEN ONSET AND DEATH <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Moderate Anemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/21</u> , 19 <u>67</u> to <u>3/24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/23</u> , 19 <u>67</u> , and that death occurred at <u>7:15</u> P.M. from causes and on the date stated above			
22a. SIGNATURE <u>Francis X. Richardson</u>		22b. DATE SIGNED <u>3/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Francis X. Richardson, M.D.</u>		22d. ADDRESS <u>11412 Viers Mill Rd., Wheaton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar 27, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>MAR 29 1967</u>	
ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



03750

CERTIFICATE OF DEATH

03745

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maplewood</b>	
c. LENGTH OF STAY IN 1b <b>180 days</b>		d. STREET ADDRESS <b>121 Oak View Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, NIH, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Morris</b> Middle <b>(NMN)</b> Last <b>Brenman</b>		4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 March 1906</b>
9. AGE (In years lost birthday) <b>60 yrs.</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Local government</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Brenman</b>		14. MOTHER'S MAIDEN NAME <b>Anna Freedman Stahl</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Not available</b>	
17. INFORMANT <b>The Medical Records, The Clinical Center, National Institutes of Health, Bethesda, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>1939</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Cerebral Edema</b> DUE TO (c) <b>Glioblastoma Multiforme</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>6 months</b> <b>1 year</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>26 September 1966</b> , to <b>25 March, 1967</b> , that (X) (we) last saw the deceased alive on <b>25 March 1967</b> , and that death occurred at <b>10:30 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>I. David Goldman</b> M.D.		22b. DATE SIGNED <b>25 March 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>I. David Goldman, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/27/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Temple Emanuel Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>New Jersey</b>
24. FUNERAL DIRECTOR <b>Bernard Danzansky &amp; Sons</b>		25a. REC'D BY REGISTRAR <b>St. Wash. D.C.</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03751

## CERTIFICATE OF DEATH

03746

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>5 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>714 Sligo Avenue</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>714 Sligo Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Alonzo</b> First <b>Frank</b> Middle <b>Bruffy</b> Last SEX <b>Male</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired operator</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Variety Store</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Richmond, Virginia</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		4. DATE OF DEATH <b>March 26 19 67</b> 8. DATE OF BIRTH <b>Nov 28, 1886</b> 9. AGE (In years last birthday) yrs. <b>80</b> IF UNDER 1 YEAR Months Days Hours Min 13. FATHER'S NAME <b>Alonzo Bruffy</b> 14. MOTHER'S MAIDEN NAME <b>Martha Mills</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b> <b>WWI</b> 16. SOCIAL SECURITY NO <b>578-26-5285</b> 17. INFORMANT <b>Drene Bruffy</b> Address <b>714 Sligo Avenue Silver Spring, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURE OF ABDOMINAL ANEURYSM</b> DUE TO <b>457X</b> (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>5 YRS.</b> <b>5 YRS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-9, 1967</b> to <b>3-21, 1967</b> , that (I) (we) last saw the deceased alive on <b>3-21, 1967</b> , and that death occurred at <b>11/4 M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>L. B. Snow</b>		22b. DATE SIGNED <b>3/27/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. B. Snow</b>		22d. ADDRESS <b>7950 N. H. Ave., Langley Park, Md.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar 29, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co., Md.</b>	
24. FUNERAL DIRECTOR <b>John B. Thomas</b> <b>Warner E. Humphrey, Inc.</b>		25a. REC'D BY REGISTRAR <b>30 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the bon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03752						03747					
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Opely</u> c. LENGTH OF STAY IN 1b <u>9 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Spaake Grave Foundation</u>						2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brookeville</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Rebecca</u> Middle <u>Belle</u> Last <u>Bryan</u>		4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1967</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-31-1883</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		9. AGE (In years last birthday) <u>83</u> yrs.	
13. FATHER'S NAME <u>John Parsley</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Janglells</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>W. Russell Bryan</u> <u>Brookeville, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (b) <u>ISCHEMIC HEART DISEASE</u> DUE TO (c) <u>ARTERIO SCLEROTIC C.V. DISEASE</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>OLD STROKE - HEMI PLEGIA</u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>3</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Brookeville</u>		20g. (County) <u>Montgomery</u>		20h. (State) <u>Md.</u>		21. I certify that (I) (this hospital) attended the deceased from <u>Oct 3, 1963</u> to <u>3/7, 1967</u> , that (II) (we) last saw the deceased alive on <u>3/3, 1967</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>Donald R. Lewis</u>		22b. DATE SIGNED <u>3-8-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DONALD R LEWIS</u>		22d. ADDRESS <u>OLNEY MD</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-10-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Burtonsville</u>		23d. LOCATION (City, town or county) (State) <u>Burtonsville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u>		ADDRESS <u>Laytonsville, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03753

CERTIFICATE OF DEATH

03748

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) ✓ a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fulton, Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Inga</b> Middle <b>Buckman</b> Last <b>Buckman</b>		4 DATE OF DEATH Month <b>Mar.</b> Day <b>21</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 16 1896</b> 9. AGE (In years lost birthday) <b>70</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Norway</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Johanne Gunderson</b>		14. MOTHER'S MAIDEN NAME <b>Christine Johnson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Montgomery Gen. Hospital</b>		Address <b>Olney, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Intestinal Obstruction</b> <b>1538</b> DUE TO <b>Metastatic Adenocarcinoma of Colon</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>6 mo</b> DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>3/21/67</b> pm <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>66</b>	20f. (City or town) <b>3/21/67</b> (County) <b>1307</b> (State)
21. I certify that (I) (this hospital) attended the deceased from <b>8</b> , 19 <b>67</b> to <b>3/21</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3/21</b> , 19 <b>67</b> , and that death occurred <b>13:07</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>C.H. LUGOW</b>		22b. DATE SIGNED <b>3/21/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>C.H. LUGOW</b>		22d. ADDRESS <b>SANDY SPRING, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>3-23-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Louis Cem</b>	23d. LOCATION (City or Town) <b>Clarksville Md</b> (County) (State)
24. FUNERAL DIRECTOR <b>Charles Judge</b>		25a. REC'D BY REGISTRAR <b>MAR 28 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03754

CERTIFICATE OF DEATH

03749

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN TB <b>29 Days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>						d. STREET ADDRESS <b>Franklin Manor, Essex Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) <b>Sandra Lee Burke</b>		4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>19 67</b>		5 SEX <b>Female</b>		6 COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>29 February 1944</b>	
9. AGE (In years lost, birthday) <b>23 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ward Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (County & State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Robert E. Burke</b>	
14. MOTHER'S MAIDEN NAME <b>Dorcas Hunt</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Not Available</b>		17. INFORMANT <b>The Medical Records, The Clinical Center, Bethesda, Maryland 20014</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO (b) <b>Cerebral Edema</b> DUE TO (c) <b>Acute Myelogenous Leukemia</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>24 hours</b> <b>4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10 February, 19 67</b> , to <b>March 11, 19 67</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11 March 19 67</b> , and that death occurred at <b>12:25 A.M.</b> , from causes and on the date stated above.											
22a. SIGNATURE <i>Carl E. Kierney</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> A.M.				22b. DATE SIGNED <b>11 March 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Carl E. Kierney, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 14, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens</b>				23d. LOCATION (City or town) (County) (State) <b>Arlington, Virginia</b>			
24. FUNERAL DIRECTOR <b>Ives Funeral Home</b>				25a. REC'D BY REGISTRAR <b>2847 Wilson Boulevard Arlington, Virginia</b>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03755

CERTIFICATE OF DEATH

03750

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>10 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>		d. STREET ADDRESS <b>15710 NEW COLUMBIA PIKE</b>	
3. NAME OF DECEASED (Type or print) First <b>MINNIE</b> Middle <b>MAUDE</b> Last <b>BURTON</b>		4. DATE OF DEATH Month <b>3</b> Day <b>31</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-28-97</b>
9. AGE (In years last birthday) yrs <b>69</b>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Name</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>EVAN GAITHER</b>		14. MOTHER'S MAIDEN NAME <b>CARRIE MURPHY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>MEDICAL RECORDS DEPT.</b>		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction, acute</b> DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> stating the underlying cause last. (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>10 yrs</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/31</b> , 1967 to <b>3/31</b> , 1967, that (I) (we) last saw the deceased alive on <b>3/31</b> 1967, and that death occurred at <b>9:50 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>A. D. Bonifant</b>		22b. DATE SIGNED <b>3/31/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. D. BONIFANT, M. D.</b>		22d. ADDRESS <b>MEDICAL CENTER, SANDY SPRING, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-3-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Truman Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Burtonsville Md</b>	
24. FUNERAL DIRECTOR <b>De Witt Donaldson Laurel, Md</b>		25a. REC'D BY REG/STRAR <b>APR 5 1967</b>	
25b. REG/STRAR'S SIGNATURE <b>J Charles Judge</b>		25c. ADDRESS <b>W. Hammond</b>	





FOR STATE  
HEALTH DEPT.

03756

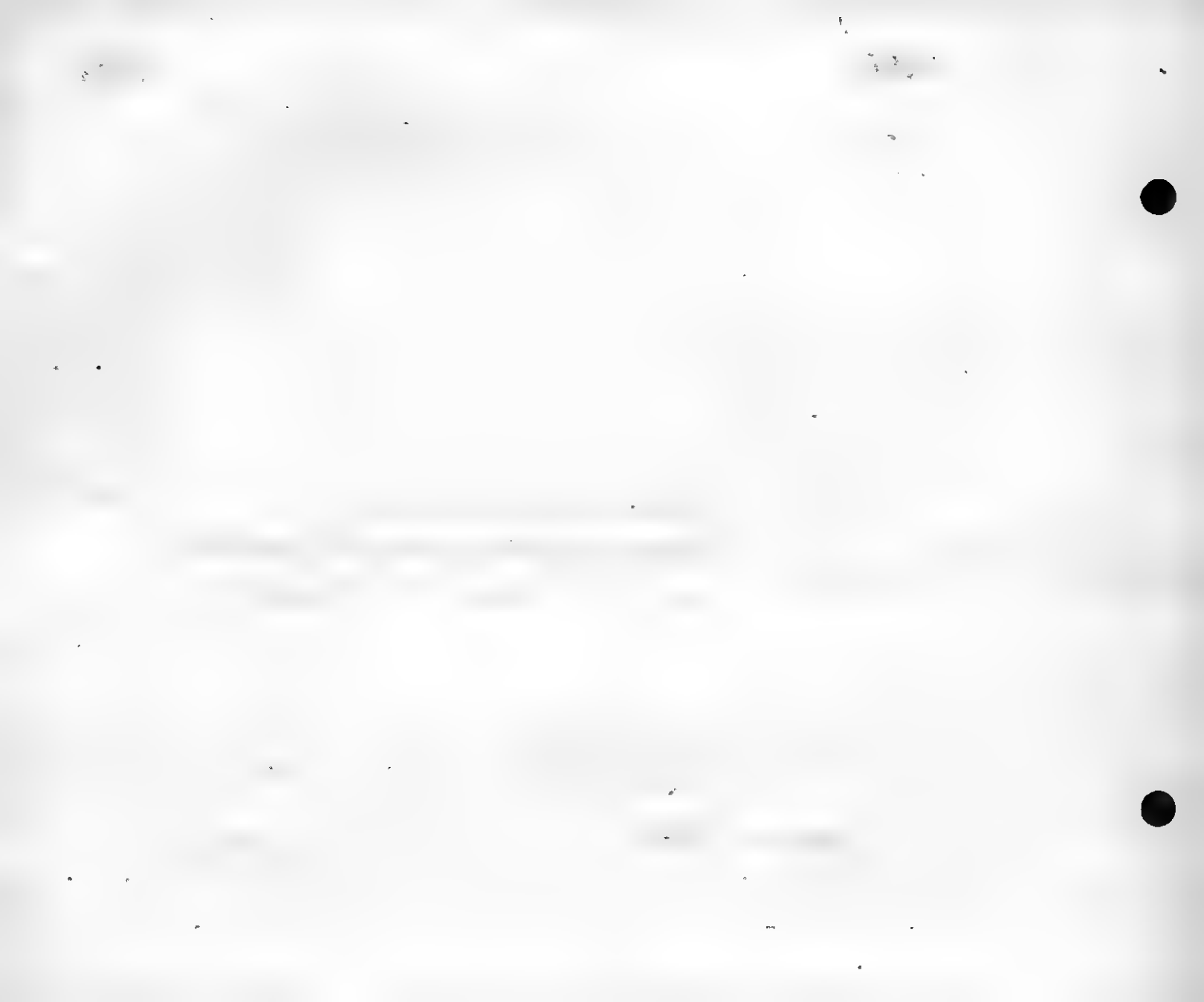
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03751

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Ohio</u> b COUNTY <u>Cleveland</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>U.O.A.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d STREET ADDRESS <u>936 - Ida St.</u>	
3. NAME OF DECEASED (Type or print) <u>Irene Helen Basinski</u>		4 DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>June 5, 1917</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) <u>Ohio</u>
13 FATHER'S NAME <u>Joseph W. Kelly</u>		14 MOTHER'S MAIDEN NAME <u>Stella Louda</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16 SOC. SEC. NO. <u>Unknown</u>	
17 INFORMANT <u>Wm. F. Basinski</u>		Address <u>Same as above</u>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Coronary Thrombosis Old &amp; Recent</u> DUE TO (c) <u>Cardio Vascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>  <u>Years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF DEATH Hour <u>19</u> a.m. <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>	
		DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/> <u>3/26/67</u>	
		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
<u>Burial-transit</u>	<u>3-27-67</u>	<u>Calvary Cemetery</u>	<u>Cleveland, Ohio</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a REC'D BY REGISTRAR <u>MAR 30 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~the~~ <sup>your</sup> papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03757

CERTIFICATE OF DEATH

03752

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>DC</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>				c. LENGTH OF STAY IN 1b <b>34 days</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>				d. STREET ADDRESS <b>1238 VAN BUREN ST., NW</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SAN., + HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>CAPLAN</b> Last <b>CAPLAN</b>				4. DATE OF DEATH Month <b>MAR.</b> Day <b>7</b> Year <b>1967</b>			
5 SEX <b>FE</b>		6. COLOR OR RACE <b>WH</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>3/15/84</b>	
9 AGE (in years last birthday) <b>86</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>ROUMANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Amer.</b>		13 FATHER'S NAME <b>SAMUEL SIEGEL</b>		14. MOTHER'S MAIDEN NAME <b>CLARA MERGLER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.		17 INFORMANT <b>HOSPITAL RECORD</b> Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Anoxia</b> DUE TO (b) <b>Myocardial Infarction</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-3</b> , 19 <b>67</b> to <b>3-7</b> , 1967, that <b>we</b> (we) last saw the deceased alive on <b>3-7</b> , 19 <b>67</b> , and that death occurred at <b>8:50 PM</b> , from causes and on the date stated above							
22a. SIGNATURE <b>Gilbert B. Cushner</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3-7-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gilbert B. Cushner</b>				22d. ADDRESS <b>11161 New Hamp. Ave. S.S.Md.</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>3/9/67</b>		23c NAME OF CEMETERY OR CREMATORY <b>King David Mem. Gar.</b>		23d. LOCATION (City or town) (County) (State) <b>Falls Church, Virginia</b>	
24. FUNERAL DIRECTOR <b>B. Hanzusky &amp; Sons</b> ADDRESS <b>3501-14th St. N.W.</b>				25a REC'D BY REGISTRAR <b>MAR 9 1967</b> DATE		25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



03758

## CERTIFICATE OF DEATH

03753

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>POTOMAC VALLEY HOSPITAL</u> <u>POTOMAC VALLEY RD.</u>		d. STREET ADDRESS <u>11807 Gainesborough Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>EVELYN</u> <u>ROSE</u> <u>CARROLL</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 21 1898</u> 68 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>
13. FATHER'S NAME <u>John G. Carter</u>		14. MOTHER'S MAIDEN NAME <u>Theresa V. Farrell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-52-5786</u>	17. INFORMANT <u>Daughter</u> Address <u>Same as Item 2.</u> <u>Mrs. H.S. Higdon</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm Accident</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>5 years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from _____, 19 <u>60</u> , to <u>3-7</u> , 19 <u>67</u> , that (2) (we) last saw the deceased alive on <u>3-7-67</u> 19 <u>67</u> , and that death occurred at <u>11:15 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Morris Perry</u>		22b. DATE SIGNED <u>3-7-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MORRIS PERRY</u>		22d. ADDRESS <u>11802<sup>nd</sup> Georgia Ave.</u> <u>Silver Spring, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-10-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cemetery, Arlington, Va.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 10 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

03759

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03754

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if within 100 miles of residence before admission) b COUNTY <u>Maryland Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c LENGTH OF STAY IN 1b <u>Silver Spring</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9511 Pin oak drive</u>		d STREET ADDRESS <u>9511 Pin oak drive</u>	
3 NAME OF DECEASED (Type or print) <u>KATHERINE R. CARSON</u>		4 DATE OF DEATH Month <u>3</u> Day <u>29</u> Year <u>1967</u>	
5 SEX <u>Fe</u>	6 COLOR OR RACE <u>CAUC</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10-20-1894</u>
9 AGE (in years, last birthday) <u>72</u> yrs		10 IF UNDER 1 YEAR Months <u>1</u> Days <u>29</u> Hours <u>19</u> Min <u>67</u>	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b KIND OF BUSINESS OR INDUSTRY <u>- - -</u>	
12a BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13 FATHER'S NAME <u>EDWARD H RIAL</u>		14 MOTHER'S MAIDEN NAME <u>LILIA R. KRAFT</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>- - -</u>		16 SOCIAL SECURITY NO <u>091-22-8110</u>	
17 INFORMANT <u>Richard E. Carson -</u>		Address <u>Pensington, Md. 9803 CULVER ST.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive left subarachnoid hemorrhage</u> DUE TO (b) <u>accompanied by chronic myelocytic leukemia</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>- - -</u>			INTERVAL BETWEEN ONSET AND DEATH <u>- - -</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>- - -</u>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>- - -</u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>-</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>- - -</u>	20f (City or town) (County) (State) <u>- - -</u>
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Keap</u> M.D.		22. DATE SIGNED <u>3/29/1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. KEAP, M.D.</u>		Address <u>Special City and County</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>3-31-1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem. Arlington Va.</u>	23d LOCATION (City or town) (County) (State) <u>- - -</u>
24 FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash. D.C.</u>		25a REC'D BY REGISTRAR <u>APR 3 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c REGISTRAR'S SIGNATURE <u>- - -</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03760

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03755

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New Hampshire</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Woodstock</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>17508 Redland Road</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>OSCAR</u> First <u>B.</u> Middle <u>CARTER</u> Last		4. DATE OF DEATH <u>March 2, 1967</u> Month <u>19</u> Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/28/93</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Mill</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New Hampshire - Errol</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ira Carter</u>		14. MOTHER'S MAIDEN NAME <u>Helen B. Straw</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>001-09-1311</u>	
17. INFORMANT <u>Herbert M. Carter</u>		17508 Redland Road Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>4401</u> DUE TO (b) <u>ESSENTIAL HYPERTENSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>CORONARY ARTERY DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 HOURS</u> <u>30 YEARS</u> <u>20 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC RENAL FAILURE - PULMONARY EMPHYSEMA</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>NOV. 7, 1966</u> to <u>MARCH 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>MARCH 1, 1967</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Gordon S. Rosenberger</u> M.D.		22b. DATE SIGNED <u>March 3, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gordon S. Rosenberger, M. D.</u>		22d. ADDRESS <u>310 West Montgomery Ave Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		23b. DATE THEREOF <u>3/5/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodstock</u>		23d. LOCATION (City, town or county) (State) <u>Woodstock, New Hampshire</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 6 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



03761

CERTIFICATE OF DEATH

03756

1 PLACE OF DEATH a COUNTY <b>MONTGOMERY</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admssn on) a. STATE <b>MARYLAND</b> b COUNTY <b>PR. GEO. MONTGOMERY</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c LENGTH OF STAY IN 1b <b>2 days 14 hrs 45 min</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SAN &amp; HOSPITAL</b>		e STREET ADDRESS <b>6805 WOODLAND AVE.</b>	
3 NAME OF DECEASED (Type or print) <b>Barbara</b> First <b>NONE</b> Middle <b>CARUSI</b> Last		4 DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-23-12</b>
9. AGE (In years last birthday) <b>54</b> yrs		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>4</b> Hours <b>1</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hotel Bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Banking</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Ga.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hall</b>		14. MOTHER'S MAIDEN NAME <b>Not available</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>213 40 7768</b>	
17. INFORMANT <b>Hospital Records</b>		Address <b>7600 Carroll Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO <b>ruptured aneurysm</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>2 days</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>3-5, 1967</b> to <b>3-7, 1967</b> , that (we) last saw the deceased alive on <b>3-7</b> 19 <b>67</b> and that death occurred at <b>7 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Gilbert B. Cushner</b> M.D.		22b. DATE SIGNED <b>3-7-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>GILBERT B. CUSHNER</b>		22d. ADDRESS <b>11161 New Hamp Ave. Sd Sp Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Mar. 10, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Colman Manor Park &amp; Co Md</b>
24. FUNERAL DIRECTOR <b>Walter W. Winters</b>		25a. REC'D BY REGISTRAR <b>MAR 10 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03762

CERTIFICATE OF DEATH

03758

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b <b>13 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SAN. &amp; HOSPITAL</b>		e. STREET ADDRESS <b>122 Ritchey Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>MARTHA KATHERINE CLARK</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>12</b> Year <b>1967</b>	
5. SEX <b>FE</b>	6. COLOR OR RACE <b>WH</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/7/92</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES B. KIRK</b>		14. MOTHER'S MAIDEN NAME <b>Ida Bealle</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest.</b> DUE TO (b) <b>Myocardial ischemia</b> DUE TO (c) <b>Severe Rt &amp; Lt. Heart Failure</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cor Pulmonale; Possible CNS Disease; Embolus; Congestive Heart Failure</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>Feb 28</b> , 1967, to <b>Mar 12</b> , 1967, that (2) (we) last saw the deceased alive on <b>Mar 12</b> , 1967, and that death occurred at <b>1:00 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Welford D. Meyers M.D.</b>		22b. DATE SIGNED <b>Mar 13, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Welford D. Meyers M.D.</b>		22d. ADDRESS <b>8323 Haddon Dr. Takoma Park Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>3/15/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>	23d. LOCATION (City or Town) (County) (State) <b>SIL. SPRING MONTGOMERY MD.</b>
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS, Inc.</b>		25a. REC'D BY REGISTRAR <b>MAR 14 1967</b>	
ADDRESS <b>SILVER SPRING</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
03763		03759	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
a. COUNTY	Montgomery	a. STATE	Maryland
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	Chevy Chase	b. COUNTY	Montgomery
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	CHEVY CHASE
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	19 Grafton Street	d. STREET ADDRESS	19 GRAFTON STREET
3. NAME OF DECEASED (Type or print)	First Middle Last	4. DATE OF DEATH	Month Day Year
	NAYAN IDA COBB		March 10 19 67
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Female	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8/25/85
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
School Principal	Chevy Chase Country day Sch.	Toronto, Canada	U.S.A.
13. FATHER'S NAME	MOTHER'S MAIDEN NAME		
- Whitlam	Unobtainable		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
no	215-34-3281	Stanwood Cobb	same as above
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)			
X DUE TO			
Conditions, if any, which gave rise to immediate cause (b)			
(c), stating the underlying cause last.			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
Left - Hemiplegia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year			
Hour a.m. 19			
p.m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Nov. 4, 1967, to Mar. 10, 1967, that (I) (we) last saw the deceased alive on Mar. 4, 1967, and that death occurred at 8:45 AM, from the causes and on the date stated above.			
22a. SIGNATURE			
22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Frank S. Bacon			
22d. ADDRESS			
2141-K-ST. N.W.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			
23b. DATE THEREOF			
23c. NAME OF CEMETERY OR CREMATORY			
23d. LOCATION (City, town or county) (State)			
Burial 3/13/67 Rock Creek Cemetery Washington, D. C.			
24. FUNERAL DIRECTOR'S SIGNATURE			
25. REC'D BY REGISTRAR			
25a. REGISTRAR'S SIGNATURE			
The S. H. Hines Company Washington, DC MAR 13 1967 Charles Judge			





03764

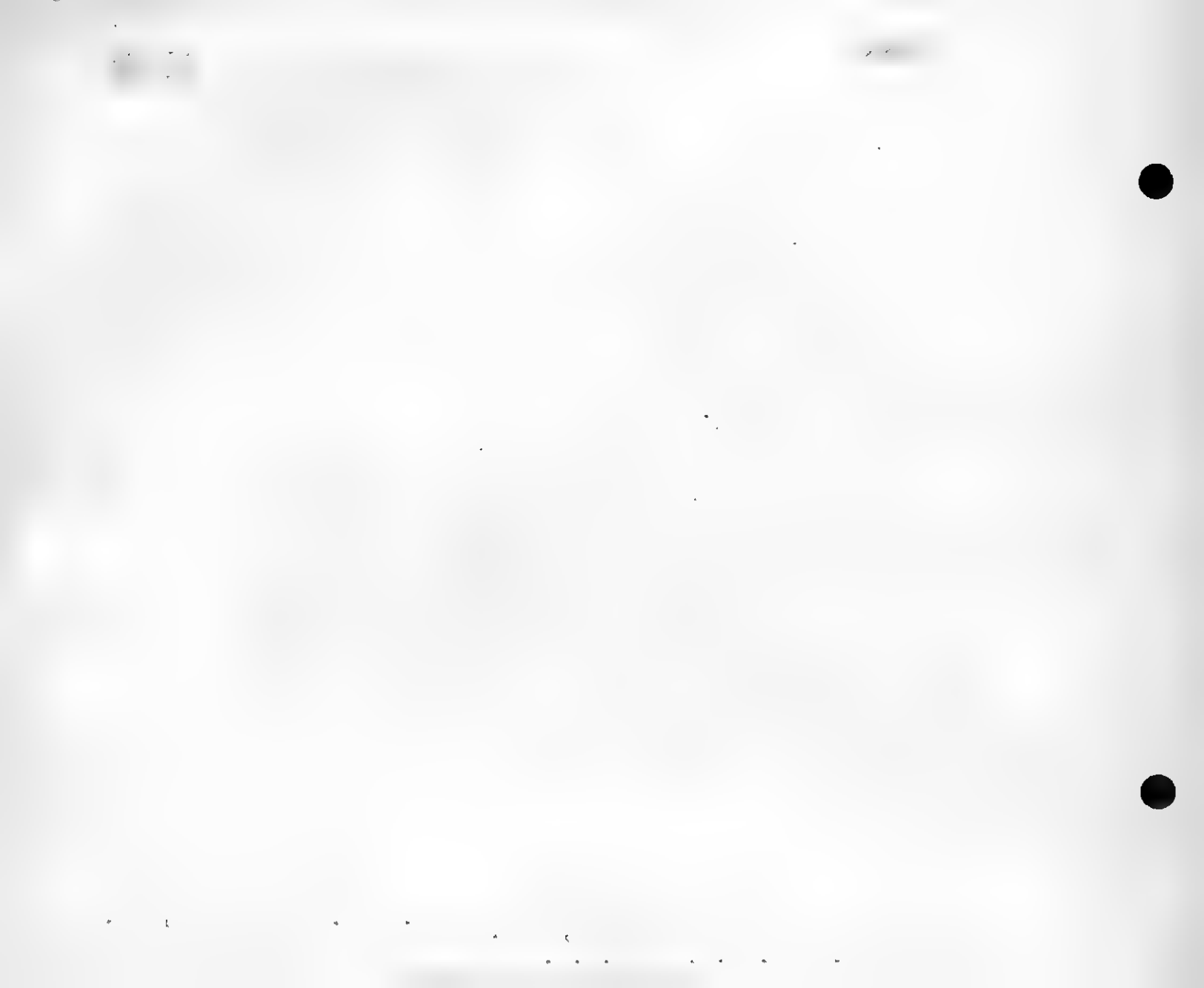
## CERTIFICATE OF DEATH

03760

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick</u>		d. STREET ADDRESS <u>6400 - Brookville Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Thomas Cochran</u>		4. DATE OF DEATH <u>March 13 1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 1892</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR: Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Editor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Citizen</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Lodge Cochran</u>		14. MOTHER'S MAIDEN NAME <u>Whiteacre</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes, U.S. Army</u>		16. SOCIAL SECURITY NO. <u>449-46-1618</u>	
17. INFORMANT <u>Robert Thomas Cochran</u>		Address <u>See item 14</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>15 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> , 19 <u>13</u> Mar, 1967, that (I) (we) last saw the deceased alive on <u>13 Mar 1967</u> , and that death occurred at <u>11:00</u> P.M., from causes and on the date stated above			
22a. SIGNATURE <u>H. A. Grennan</u>		22b. DATE SIGNED <u>13 Mar 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. A. GRENNAN</u>		22d. ADDRESS <u>2001 E St NW, Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>3-17-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Alexandria Nat'l Cem., Alexandria, Va.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
5130 Wisc. Ave. N.W. Wash. D.C.		DATE <u>MAR 20 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03765				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				03761			
1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if inst. on Res. dence before admission) a STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>						d STREET ADDRESS <u>9609 Avenel Road</u>				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>REBECCA</u> Middle <u>PAULINE</u> Last <u>COHN</u>						4 DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>1967</u>					
5 SEX <u>Female</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>3/4/1891</u>		9 AGE (In years last birthday) <u>76</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Poland</u>				12 CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Jacob Keroes</u>						14 MOTHER'S MAIDEN NAME <u>Rosa</u>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16 SOCIAL SECURITY NO		17. INFORMANT Address <u>Edward Stern - 9609 Avenel Rd., Sil. Sp., Md</u>					
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) - <u>Coronary Insufficiency Acute</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } ost } (b) <u>CardioVascular Disease</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>Several</u> <u>years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Bernard Danzansky &amp; Sons</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 3/22/67					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
Address (Street, city, town, or county)						22. DATE SIGNED					
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b DATE THEREOF <u>3/24/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Wash. Heb. Cong. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Wash. D.C.</u>			
24. FUNERAL DIRECTOR <u>Bernard Danzansky &amp; Sons St. NW, Wash. D.C.</u>						25a REC'D BY REG STRAR <u>MAR 27 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



03766

## CERTIFICATE OF DEATH

03762

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville 8000</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>4744 - Hampshire Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Antigone Nicholas (Wife)</u>		4. DATE OF DEATH <u>March 22 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7 JUNE 1895</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Turkey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Demetris Nicholas</u>		14. MOTHER'S MAIDEN NAME <u>MERSINI (UNKNOWN)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>UNKNOWN</u>	
17. INFORMANT <u>Constantine Christas a son</u>		Address <u>5501</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT (2ND)</u> DUE TO (b) <u>CEREBRAL VASCULAR ACCIDENT (1ST)</u> DUE TO (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 HOURS</u> <u>1 WEEK</u> <u>AT LEAST 10 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>(1) ACUTE CONGESTIVE CARDIAC FAILURE (2) UREMIA.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>—</u>
21. I certify that (1) (this hospital) attended the deceased from <u>AUGUST</u> , 1966, to <u>MARCH 22</u> , 1967, that (1) (we) last saw the deceased alive on <u>MARCH 22</u> , 1967, and that death occurred at <u>8 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Nicholas Madeloff</u>		22b. DATE SIGNED <u>3/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Nicholas Madeloff</u>		22d. ADDRESS <u>10620 GEORGIA AVE. SILVER SPRING MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>25 MAR 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY BLADENSBURG MD.</u>	23d. LOCATION (City or Town) (County) (State) <u>—</u>
24. FUNERAL DIRECTOR <u>RINALDI FUNERAL HOME INC</u>		25a. REC'D BY REGISTRAR <u>RECORDED</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 28 1967</u>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03767

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03763

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if installed on Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring (Wheaton)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Howard Johnson Motel</u>		d. STREET ADDRESS <u>Box 130, Windsor Mill Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LLOYD E. CONTANT</u>		4. DATE OF DEATH Month Day Year <u>MARCH 25 19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/23/63</u>
9. AGE (In years last birthday) <u>64</u> yrs		10. F UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Rochester, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. A. Contant</u>		14. MOTHER'S MAIDEN NAME <u>Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>Mrs. Maryona A. Contant</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) <u>Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour or p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Keap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. KEAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>3/25/1967</u>	
Address (Street, city, town or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>3-27-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> (Bethesda, Md.)		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>MAR 30 1967</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE	





DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03768

03764

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN b. <u>6 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>417 Southwest Drive</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>417 Southwest Drive</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Ina</u>		First <u>M.</u> Middle <u>Cook</u> Last		<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>2</u> Year <u>1967</u>			
<b>5. SEX</b> <u>female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>March 9, 1883</u>			
<b>9. AGE</b> (In years last birthday) <u>83</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u>		<b>11. IF UNDER 24 HRS.</b> Hours <u>0</u> Min. <u>0</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired clerk</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Department Store</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Kentucky</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Unknown Sandefur</u>					
<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary J. Nichols</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Mrs. Earle Wallick</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>20g. (County)</b>		<b>20h. (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from....., 1966 to 2 March, 1967 that (I) (we) last saw the deceased alive on 2 March, 1967, and that death occurred at 3:00 PM from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>William And</u>		<b>22b. DATE SIGNED</b> <u>3/2/67</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>William And</u>			
<b>22d. ADDRESS</b> <u>9001 Colesville Rd., S. S., Md.</u>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Trans-burial March 6, 1967</u>					
<b>23b. DATE THEREOF</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Sterling Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) <u>Sterling, Illinois</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Glen Carter</u>		<b>24b. ADDRESS</b> <u>8434 Georgia Ave. Silver Spring, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u>			
<b>25b. REGISTRAR'S SIGNATURE</b>		<b>DATE</b> <u>MAR 6 1967</u>					



03769

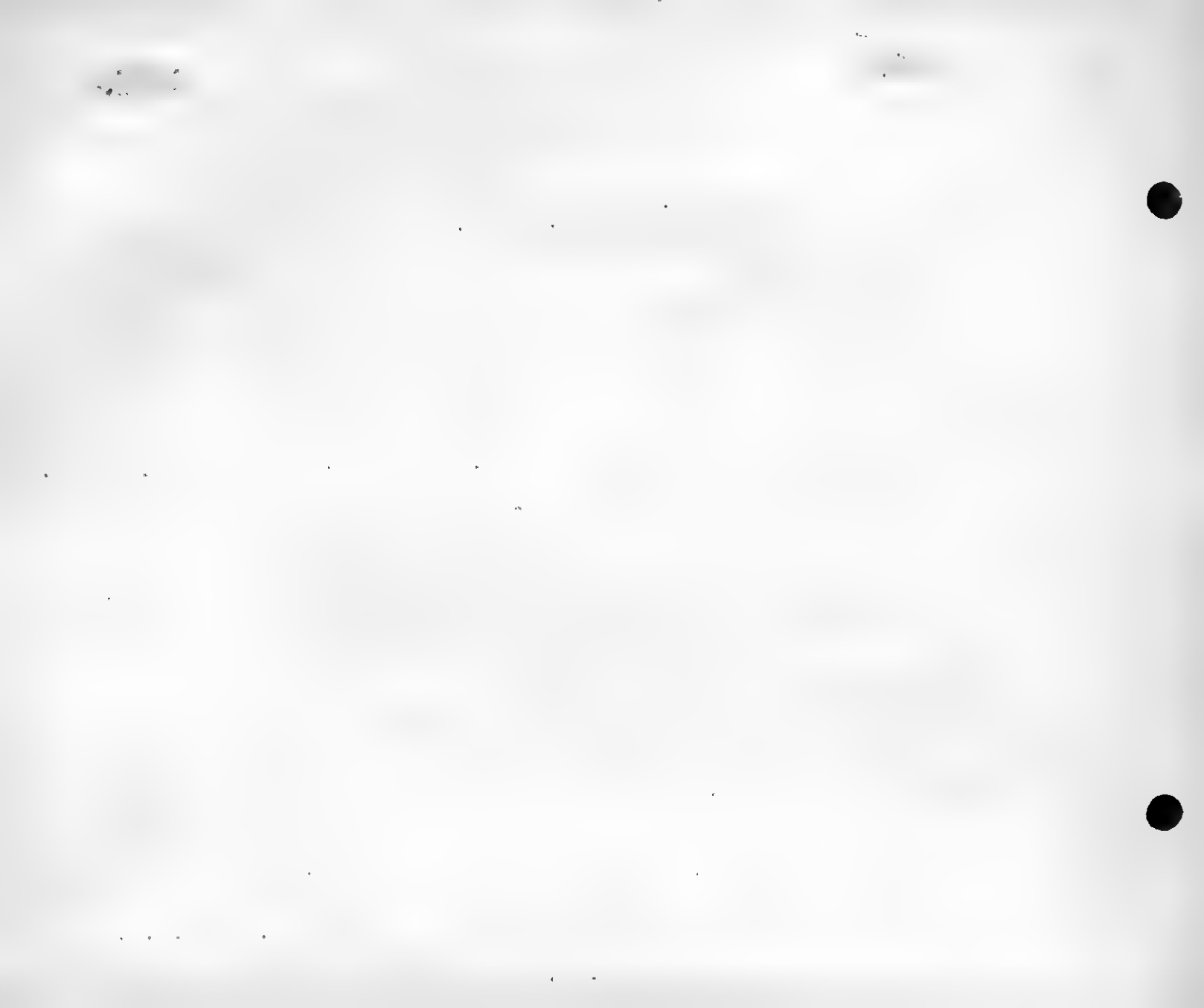
## CERTIFICATE OF DEATH

03765

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c LENGTH OF STAY IN 1b <u>Silver Spring</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chevy Chase Nsg. &amp; Conv. Home</u> <u>2015 E. West Highway, Silver Spring, Md.</u>		d STREET ADDRESS <u>8201 16th St.</u>	
3 NAME OF DECEASED (Type or print) <u>Abel</u>		4 DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Cau.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10/24/98</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Comptroller</u>		10b KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) yrs <u>68</u> IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
11 BIRTH PLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Nathan</u>		14 MOTHER'S MAIDEN NAME <u>Coplan, Celia</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WWI</u>		16 SOCIAL SECURITY NO <u>577-03-0278</u>	
17 INFORMANT <u>Wife</u>		Address <u>8201-16th St. Sil Sp. Md.</u>	
18a CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cessation Resp</u> DUE TO <u>330X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Cerebral thromboses</u> (c) <u>Cerebral arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 mrs</u> <u>2 wks</u> <u>10 mrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>1955</u> , 19 <u>  </u> , to <u>MARCH</u> , 19 <u>67</u> , that (I) <del>(was)</del> last saw the deceased alive on <u>3/17/67</u> 19 <u>  </u> , and that death occurred at <u>2:20 PM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Milton Gussak</u>		22b DATE SIGNED <u>3/18/67</u>	
22c PHYSICIAN'S NAME (Type) <u>Milton Gussak, M.D.</u>		22d ADDRESS <u>1302-18th NW, Wash. DC 20036</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>3/20/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Chev Sholom-Talmud Torah Cem</u>	23d LOCATION (City or Town) (County) (State) <u>Wash. D.C.</u>
24 FUNERAL DIRECTOR <u>Bernard Danzansky &amp; Sons</u>		25a REC'D BY REGISTRAR <u>St. NW, Wash. DC</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		MAR 21 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03771

## CERTIFICATE OF DEATH

03767

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOLY CROSS HOSPITAL</b>		d. STREET ADDRESS <b>3006 DAWSON AVENUE</b>	
3 NAME OF DECEASED (Type or print) First <b>CARL</b> Middle <b>Dennis</b> Last <b>CRIST</b>		4. DATE OF DEATH <b>MARCH 23 1967</b>	
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>2/18/00</b>
9 AGE (In years last birthday) <b>67 yrs</b>		10 IF UNDER 1 YEAR Months <b>23</b> Days <b>19</b> Hours <b>67</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Naval Ord. Lab.</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Crist</b>		14 MOTHER'S MAIDEN NAME <b>Lucy Fultz</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16 SOCIAL SECURITY NO. <b>579-03-5124</b>	
17. INFORMANT <b>Dorothy Robinson</b>		Address <b>3707 Delano Street Silver Spring, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <b>Serum Hepatitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Transfusion for Severe Anemia</b> (c) <b>Leukemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>9 mos.</b> <b>9 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prostatic Inflammation</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-13</b> , 19 <b>67</b> , to <b>3-23-67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3-23-67</b> , 19 <b>67</b> , and that death occurred at <b>2:15 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Morris Perry</b>		22b. DATE SIGNED <b>3-23-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Morris Perry</b>		22d. ADDRESS <b>11602 Georgia Ave., Silver Spring, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Trans-Burial</b>		23b DATE THEREOF <b>Mar 27, 1967</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Stonewall Jackson Memorial</b>		23d LOCATION (City or Town) (County) (State) <b>Lexington, Virginia</b>	
24 FUNERAL DIRECTOR <b>John B. Thomas</b>		25a REC'D BY REGISTRAR <b>27 1967</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c REGISTRAR'S NAME <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Filed 3/13/67

03772

CERTIFICATE OF DEATH

03768

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		c. LENGTH OF STAY IN Tb <b>2 months</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		d. STREET ADDRESS <b>2722 73rd Pl., Hyattsville</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>George Holmes Crocker</b>		4 DATE OF DEATH Month <b>3</b> Day <b>3</b> Year <b>1967</b>		5 SEX <b>Male</b>		6 COLOR OR RACE <b>White</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8 DATE OF BIRTH <b>2/14/1889</b>		9 AGE (In years last birthday) yrs. <b>78 7/9</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanical engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <b>Great Barrington, Mass.</b>	
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13 FATHER'S NAME <b>Frederick Crocker</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Holmes</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWI &amp; WWII</b>		16 SOCIAL SECURITY NO <b>177-10-5245</b>	
17. INFORMANT <b>Hospital Records</b>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Prostate</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>with metastases</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21 I certify that (I) (this hospital) attended the deceased from <b>Nov 4, 1964</b> to <b>March 3, 1967</b> , and that death occurred at <b>4 P.M.</b> from causes and on the date stated above.		22a. SIGNATURE <b>William Brannin M.D.</b>		22b. DATE SIGNED <b>3/3/67</b>		22c. PHYSICIAN'S NAME (Type) <b>WM BRANNIN</b>	
22d. ADDRESS <b>6124 Central Ave, Capitol Heights</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>3/4/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lees Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington D.C.</b>	
24 FUNERAL DIRECTOR <b>J. Wm. Lees Sons</b>		25a. REC'D BY REGISTRAR <b>MAR 8 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>300 4th St. NE. Wash. DC</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove covering papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03773

CERTIFICATE OF DEATH

03769

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hillendale</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillendale</u>	
c. LENGTH OF STAY IN 1b <u>24 days</u>		d. STREET ADDRESS <u>1600 Oakhawn Ct.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San + Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Catherine Lee Crummitt</u>		4 DATE OF DEATH Month <u>3</u> Day <u>7</u> Year <u>19 67</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-29-09</u> 9. AGE (In years last birthday) <u>57</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Crupper</u>		14. MOTHER'S M maiden name <u>Rose Hunt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Washington San + Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (a) <u>cholinergic crisis</u> DUE TO (b) <u>uremia</u> DUE TO (c) <u>kidney insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>— carcinoma of the liver.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-7-67</u> , 19 <u>67</u> , to <u>3-7-67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-29-67</u> , 19 <u>67</u> , and that death occurred at <u>4:45 P.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>Rose Hunt</u>		22b. DATE SIGNED <u>3-8-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>VERONICA TROOST</u>		22d. ADDRESS <u>10236 N. H. Ave. S.S. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-10-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Warrenton</u>	23d. LOCATION (City or Town) (County) (State) <u>Warrenton, Jefferson, Va.</u>
24. FUNERAL DIRECTOR <u>MOSE R FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>9</u> 25b. REG STRAUS SIGNATURE <u>Charles Judge</u>	



03774

## CERTIFICATE OF DEATH

03770

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. LENGTH OF STAY IN 'b' <u>3 1/2 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>Kensington Gardens Sanatorium</u>		d. STREET ADDRESS <u>1942 Rosemary Hills Dr. Silver Spring</u>	
3. NAME OF DECEASED (Type or print) <u>CLARA</u> First <u>Ware</u> Middle <u>Cushman</u> Last		4. DATE OF DEATH Month <u>Mar</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 10 1893</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>VERMONT</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H. Ware</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Church</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>070-20-0445</u>	
17. INFORMANT <u>Elizabeth Arnold</u>		Address <u>1942 Rosemary Hills Dr. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic cerebral</u> DUE TO (b) <u>cardiovascular disease</u> DUE TO (c) <u>lost</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 29, 1967</u> to <u>Mar 13, 1967</u> that (I) (two) last saw the deceased alive on <u>3/13</u> 1967, and that death occurred at <u>11:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>3/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. F. Kreuzburg</u>		22d. ADDRESS <u>2852 16th Ave Wash D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>Mar 14, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Mar 16 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03775

## CERTIFICATE OF DEATH

03771

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maryland</b>		c LENGTH OF STAY IN 1b <b>30 days</b>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dorloo</b>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>		d STREET ADDRESS <b>P.O. Box 48</b>	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Eugene</b> Last <b>Davey</b>		4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>25 March 1908</b>
9. AGE (In years lost birthday) yrs <b>58</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>8</b> Hours <b></b> Min. <b></b>	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seaman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Merchant Marine</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Nebraska</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Davey</b>		14. MOTHER'S MAIDEN NAME <b>Hilda Paulson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO <b>564-18-4272</b>	
17. INFORMANT <b>The Medical Records</b>		Address <b>The Clinical Center, Bethesda, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO <b>insufficiency and tricuspid insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Rheumatic heart disease; mitral stenosis and/</b> DUE TO <b>tricuspid annuloplasty</b> (c) <b>Post-operative mitral valve replacement and/</b>			INTERVAL BETWEEN ONSET AND DEATH <b>45 minutes</b> <b>15 years</b> <b>19 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>(A)</b> (this hospital) attended the deceased from <b>3 February, 1967</b> , to <b>5 March, 1967</b> , that <b>(X)</b> (we) lost saw the deceased alive on <b>5 March 19 67</b> , and that death occurred at <b>11:45M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Hamner Hannah III</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>6 March 1967</b>
22c. PHYSICIAN'S NAME (Type) <b>Hamner Hannah, III, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3-9-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT PEACE CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>MINERSVILLE, PENNA</b>
24. FUNERAL DIRECTOR <b>William M. Hysong</b> ADDRESS <b>WASH., D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 7 1967</b>	
<b>HYSONG FUNERAL HOME - 1300-N ST., N.W.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03776

## CERTIFICATE OF DEATH

03772

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		
c. LENGTH OF STAY IN lb			d. STREET ADDRESS <b>8506 Bradmoor Drive</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kensington Gardens Nursing Home</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3 NAME OF DECEASED (Type or print) <b>Laura Wise David</b>			4 DATE OF DEATH <b>MARCH 15 1967</b>		
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>10-20-1873</b>	9 AGE (In years last birthday) <b>93</b> yrs	10 IF UNDER 1 YEAR Months Days
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>			10b KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>
12 CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			13 FATHER'S NAME <b>Leo A. Wise</b>		
14 MOTHER'S MAIDEN NAME <b>Bertha Kohn</b>			15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>- - -</b>		
16 SOCIAL SECURITY NO <b>577-66-1290</b>			17 INFORMANT <b>Mr. Leo David - See Item # 2.</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CONGESTIVE HEART FAILURE</b> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>15 YEARS</b>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MULTIPLE SMALL STROKE SYNDROME</b>					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town) (County) (State)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <b>2/11/67</b> , to <b>3/15/67</b> , that (I) (we) last saw the deceased alive on <b>3/11/67</b> , and that death occurred at <b>8:35</b> M. from causes and on the date stated above.					
22a SIGNATURE <b>Horace H. Custis Jr.</b>			22b DATE SIGNED <b>3/15/67</b>		
22c PHYSICIAN'S NAME (Type) <b>HORACE H. CUSTIS JR.</b>			22d ADDRESS <b>1852 COLUMBIA RD NW</b>		
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>3-17-1967</b>		23c NAME OF CEMETERY OR CREMATORY <b>Washington Hebrew Congregation, Washington, D.C.</b>	
23d LOCATION (City or Town) (County) (State)		24 FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>			
25a REL'D BY REGISTRAR <b>MAR 20 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03777

CERTIFICATE OF DEATH

03773

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if inst. ltr on: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN lb <b>1 day</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenelg</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		d. STREET ADDRESS <b>---</b>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) <b>MARVIN WILSON DAY</b>		4. DATE OF DEATH Month <b>3</b> Day <b>10</b> Year <b>67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/10/87</b>
9 AGE (In years lost birthday) <b>79 yrs</b>		IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>19</b> Min <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13 FATHER'S NAME <b>Joshua B. Day</b>	
14 MOTHER'S MAIDEN NAME <b>Laura Hobbs</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)	
16 SOCIAL SECURITY NO. <b>218-36-1922</b>		17 INFORMANT <b>Hospital Records, Olney, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs.</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) <b>Diabetes mellitus; coronary sclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <del>did not</del> attended the deceased from <b>11-2-</b> , 19 <b>46</b> to <b>3-10-</b> , 1967, that (I) <del>was</del> <b>was</b> saw the deceased alive on <b>3-10-</b> 19 <b>67</b> , and that death occurred at <b>6:00P</b> M, from causes and on the date stated above			
22a. SIGNATURE <b>Charles S. Whitaker</b>		22b. DATE SIGNED <b>3-10-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles Whitaker, M.D.</b>		22d. ADDRESS <b>Clarksville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-13-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View</b>	23d. LOCATION (City or Town) (County) (State) <b>Alpha, Md</b>
24. FUNERAL DIRECTOR <b>F.C. Higinbotham, Ellicott City, Md</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 13 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



03778

## CERTIFICATE OF DEATH

03774

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution an Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>10103 Huest St</u>	
3 NAME OF DECEASED (Type or print) <u>IDA</u> First <u>M</u> Middle <u>DEADLY</u> Last		4. DATE OF DEATH Month <u>MARCH</u> Day <u>16</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-8-88</u> 9 AGE (In years last birthday) <u>78</u> yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered Nurse</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Ac-Cred</u>	11 BIRTHPLACE (County & State, or foreign country) <u>Worcester, MASS</u>
13. FATHER'S NAME <u>William Burke</u>		14 MOTHER'S MAIDEN NAME <u>Margaret Marisey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	17 INFORMANT <u>Lucille P. Burke</u> Address <u>same as above</u>
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4101 DUE TO (b) <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Coronary arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>7 hours</u> <u>years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>63</u> , to <u>March 16</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 16</u> 19 <u>67</u> , and that death occurred at <u>6:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert N. Coale</u>		22b DATE SIGNED <u>March 16, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u>		22d ADDRESS <u>4429 Bradley Lane, Chevy Chase Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>3-17-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Bridget's Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Plainville, Mass.</u>
24. FUNERAL DIRECTOR <u>Joe Rowlen Inc</u>		25. REG'D BY REGISTRAR <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03779

## CERTIFICATE OF DEATH

03775

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home</u>		d. STREET ADDRESS <u>3900 Cathedral Ave N.W.</u>	
3 NAME OF DECEASED (Type or print) First <u>ELODA</u> Middle <u>B.</u> Last <u>DEAN</u>		4. DATE OF DEATH Month <u>MAR.</u> Day <u>3</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-7-1899</u> 88 yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>	11. BIRTHPLACE (County & State, or foreign country) <u>MO.</u>
13. FATHER'S NAME <u>EZRA DEAN</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET Golden</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mona Brownlee</u> Address <u>Wash., D.C. 3900 Cath. Ave. NW</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CEREBRO VASCULAR DISEASE</u> DUE TO <u>334A</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 YRS</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/16</u> , 19 <u>66</u> to <u>3 MARCH</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2 MARCH</u> 19 <u>67</u> , and that death occurred at <u>10:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Walter E. Goorh</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>3 MAR 67</u>
22c. PHYSICIAN'S NAME (Type) <u>WALTER E. GOORH MD</u>		22d. ADDRESS <u>2309 SHOREFIELD RD WHEATON, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>MAR. 7 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bucklin Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Bucklin MD.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler Sons</u>		25a. REG. D. BY REGISTRAR <u>5730 Wise Ave. N.W. D.C.</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03780

03776

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an Res dence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>10 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>James Edward Dean</u>		4 DATE OF DEATH <u>3-29</u> 19 <u>67</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8-20-87</u> 19 <u>79</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington D.C.</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>James Dean</u>		14 MOTHER'S MAIDEN NAME <u>Emma Gooden</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>377-12-3113</u>	
17 INFORMANT <u>Mary Dean</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLISM</u> DUE TO <u>1500</u> (b) <u>PROSTATIC HYPERTROPHY</u> DUE TO <u>6 YR.</u> (c) <u>ARTERIO SCLEROSIS</u> AGE <u>19</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 HR.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>66</u> , to <u>MARCH</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/28</u> 19 <u>67</u> , and that death occurred at <u>11A</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>3/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>LEO J DONOVAN MD</u>		22d. ADDRESS <u>6218 WISC. AVE BETHESDA</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-1-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince George County, Md.</u>
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>APR 3 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>





03781

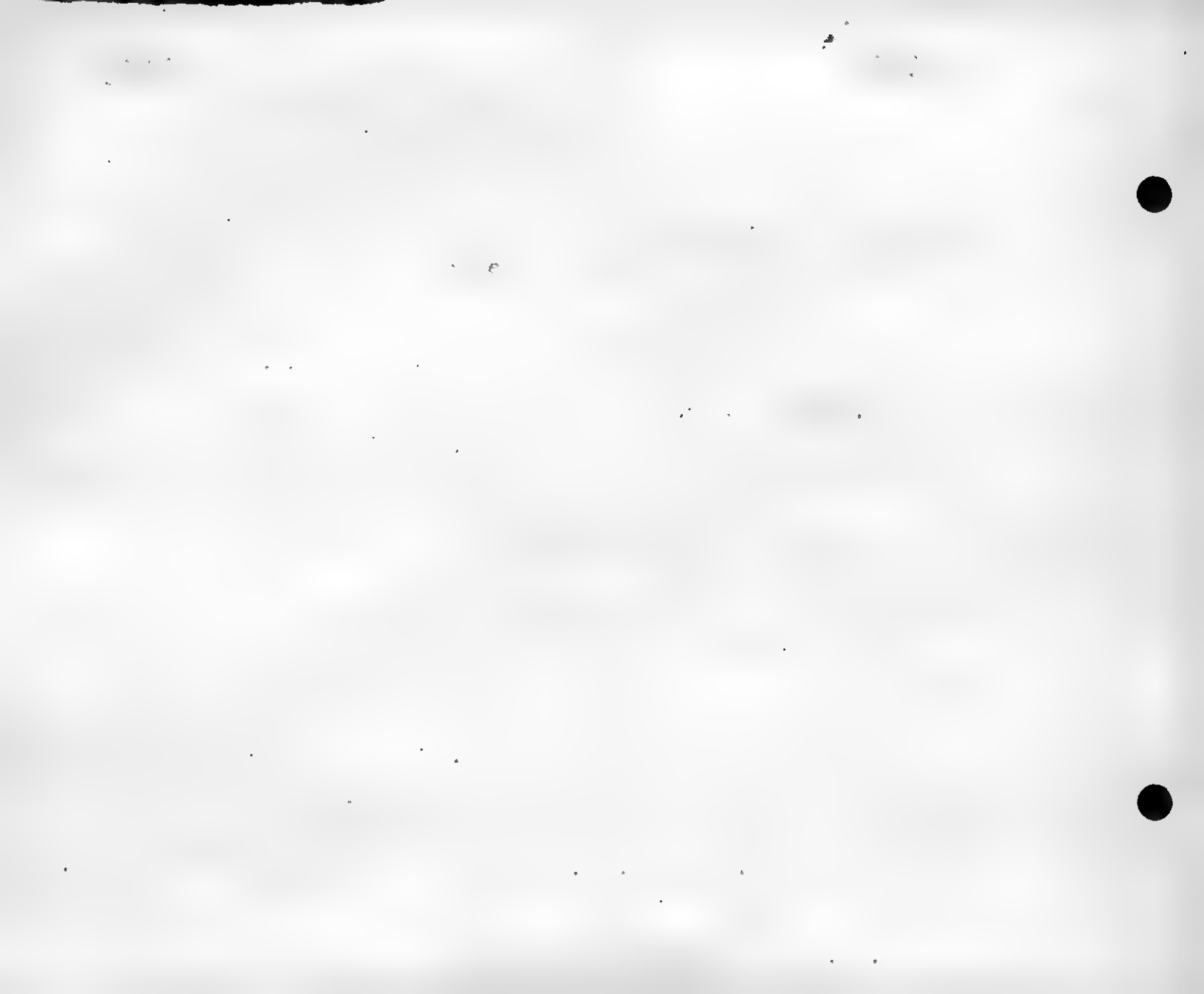
## CERTIFICATE OF DEATH

03777

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>	
c. LENGTH OF STAY IN 1b <b>23 days</b>		d. STREET ADDRESS <b>809 South Veitch Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Henry Kindred De Loatche</b>		4. DATE OF DEATH Month Day Year <b>March 16 1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 October 1961</b>
9 AGE (In years last birthday) <b>5</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min <b>5</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry K. De Loatche, Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Frances Giordano</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>The Medical Records</b>		Address <b>The Clinical Center, Bethesda, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b> DUE TO (b) <b>Granulocytopenia</b> DUE TO (c) <b>Acute Lymphocytic Leukemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>23 days</b> <b>25 days</b> <b>2½ years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Thrombocytopenia</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>10</del> (this hospital) attended the deceased from <b>Feb. 21</b> , 1967, to <b>March 16</b> , 1967, that <del>it</del> (we) lost saw the deceased alive on <b>March 16</b> , 1967, and that death occurred at <b>7:40 M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Herbert E. Kann, Jr., M.D.</b>		22b. DATE SIGNED <b>16 March 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Herbert E. Kann, Jr., M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/20/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Beechwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Boykins, Virginia</b>	
24. FUNERAL DIRECTOR <b>The S. H. Hines Company</b>		25a. REC'D BY REGISTRAR <b>20 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03782

03778

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd's</u>		c. LENGTH OF STAY IN TB <u>Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd's</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>White Ground Rd. PO Box 76</u>				d. STREET ADDRESS <u>White Ground Rd. PO Box 76</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>T.</u> Last <u>Diggins</u>				4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1967</u>			
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>Cafored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1881</u>	9. AGE (In years or birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u> Hours <u>6</u> Min.		IF UNDER 24 HRS Hours <u>6</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Twyman</u>				14. MOTHER'S MAIDEN NAME <u>Julia</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO (b) <u>Cardio Vascular Disease</u> DUE TO (c) <u>Years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John M. Bell</u> M.D.				22. DATE SIGNED <u>3/7/67</u>			
EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3/10/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Marks Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Boyd's</u>	
24. FUNERAL DIRECTOR <u>Emmett A. ...</u>				25a. REC'D BY REGISTRAR <u>MAR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



VR A15 (4)  
25M 1/67

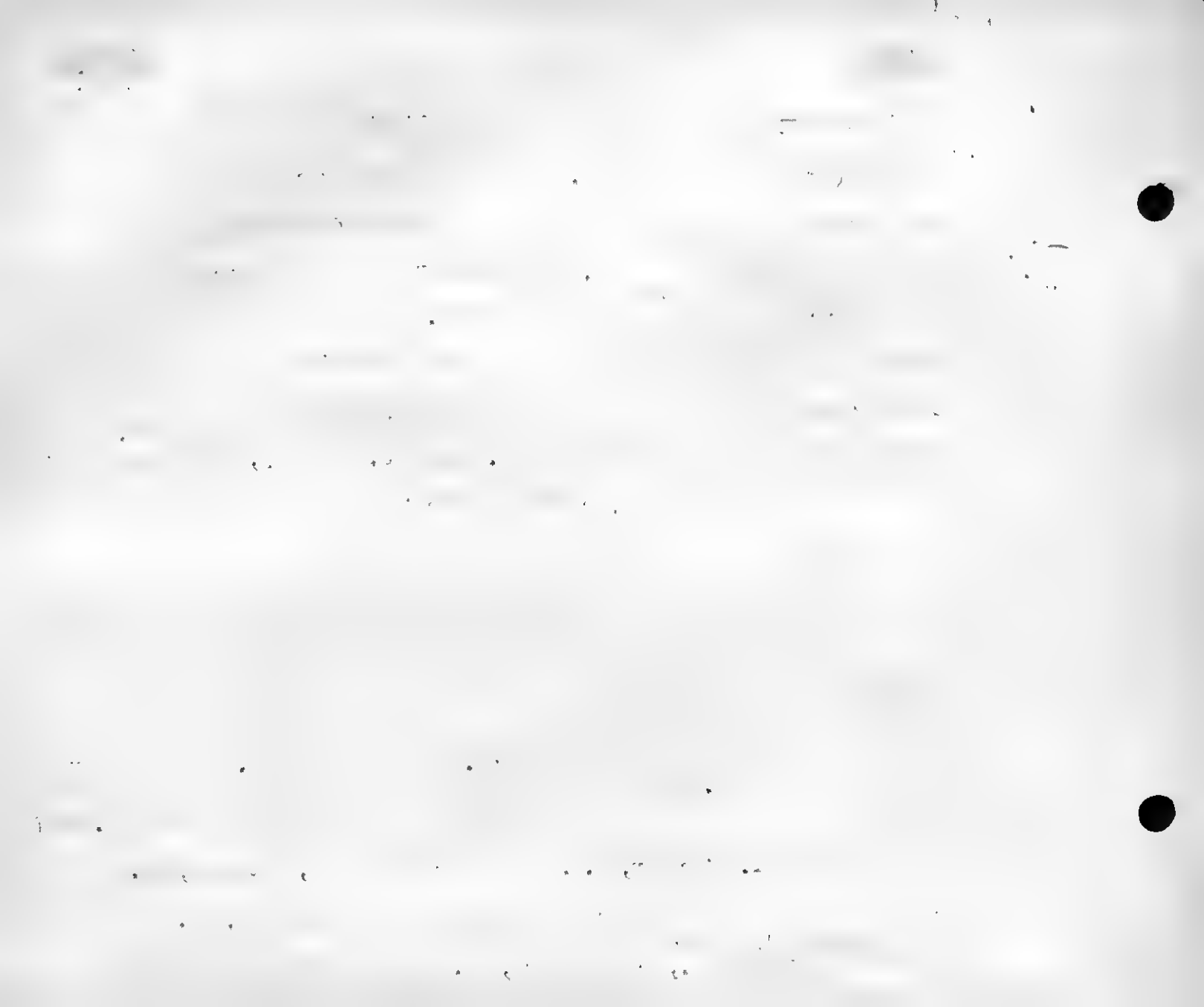
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #23b Film #1387 11/10/67

03783

CERTIFICATE OF DEATH

03779

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Falls Church</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>50 min.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Falls Church</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>			d. STREET ADDRESS <b>3020 Kadala Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Eva</b> Middle <b>J.</b> Last <b>DONNELLY</b>			4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>19 67</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>22 Feb. 1908</b>		9. AGE (In years last birthday) yrs <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of workable, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <b>West Virginia</b>	
13. FATHER'S NAME <b>James Leonard JETER</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
14. MOTHER'S MAIDEN NAME <b>Mary Steele</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO			17. INFORMANT <b>Falls Church</b> Address <b>Va.</b> <b>Mr. Daniel J. Donnelly, 3020 Kadala Place</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Mar. 20</b> , 19 <b>67</b> , to <b>Mar. 20</b> , 19 <b>67</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Mar. 20</b> , 19 <b>67</b> , and that death occurred at <b>4:50AM</b> , from causes and on the date stated above.					
22a. SIGNATURE  M.D.			22b. DATE SIGNED <b>21 Mar. 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Peter T. Kirchner, M.D.</b>
22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>	23b. DATE THEREOF <b>March 23, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>		
24. FUNERAL DIRECTOR <b>Pearson's Funeral Home</b> <b>472 North Washington St., Falls Church, Va.</b>			25a. REC'D BY REGISTRAR <b>MAR 23 1967</b>		25b. REGISTRAR'S SIGNATURE 



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03784

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03780

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c LENGTH OF STAY IN 1b			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10413 Montrose Ave. apt 102</u>				e STREET ADDRESS <u>10413 Montrose Ave. apt 102</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>MINNIE B. DOUGLAS</u>				4 DATE OF DEATH Month Day Year <u>March 22 1967</u>			
5 SEX <u>Fe</u>		6 COLOR OR RACE <u>W.</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>Mar. 12, 1900</u>	
9 AGE (In years last birthday) <u>67</u> yrs		F UNDER 1 YEAR Months Days Hours Min.		F UNDER 24 HRS Months Days Hours Min.			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Department Store-Asst Mgr., Retired</u>				10b KIND OF BUSINESS OR IND. STRY		11 BIRTHPLACE (State or foreign country) <u>New York</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13 FATHER'S NAME <u>Adolph Augustus Axinroth</u>				14 MOTHER'S MAIDEN NAME <u>Nancy Riley</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16 SOCIAL SECURITY NO <u>577-28-7560</u>		17 INFORMANT <u>Son</u> <u>Peter Douglas</u> <u>2625 N.E. 17th Ter. Ft. Lauderdale, Fla.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH CAUSED BY <u>51X</u> IMMEDIATE CAUSE (a) <u>Adenocarcinoma of pancreas with widespread metastases</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____							
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>				22. DATE SIGNED <u>3/23/67</u>			
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b DATE THEREOF <u>3-27-67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d LOCATION (City or town) (County) (State) <u>Suitland, Maryland</u>	
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a REC'D BY REGISTRAR <u>MAR 27 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





03785

CERTIFICATE OF DEATH

03781

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington - D.C.</u>		
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington - D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Center</u>			d. STREET ADDRESS <u>2800 - Ontario Rd. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u>E</u> Last <u>Doyle</u>			4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1967</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 22 - 1882</u>		9. AGE (in years last birthday) <u>85</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Wisconsin</u>	
13. FATHER'S NAME <u>Peter Roedl</u>			14. MOTHER'S MAIDEN NAME <u>Ann. Langfried</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-60-4562</u>		17. INFORMANT <u>Mary Joan Doyle</u> Address <u>same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Chronic Brain Syndrome</u>					INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>66</u> , to <u>March 30</u> , 19 <u>67</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>March 30</u> , 19 <u>67</u> , and that death occurred at <u>4:30 PM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Neil P. Campbell</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Neil P. Campbell</u>		22d. ADDRESS <u>1629 Columbia Rd</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>4/3/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. Ft. Myer, Va.</u>	
23d. LOCATION (City or town) (County) (State)		24. FUNERAL DIRECTOR <u>St. Anne's</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		25c. DATE <u>APR 4 1967</u>		25d. ADDRESS <u>2901 - 14th St N.W.</u>	



03786

## CERTIFICATE OF DEATH

03782

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
c. LENGTH OF STAY IN 1b <b>DOA</b>		d. STREET ADDRESS <b>755 Silver Spring Ave</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ruby</b> Middle <b>M</b> Last <b>Duwall</b>		4. DATE OF DEATH Month <b>3</b> Day <b>29</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/28/00</b>
9. AGE (In years last birthday) <b>66</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wade Macgruder</b>		14. MOTHER'S MAIDEN NAME <b>Ida Macgruder</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Clarence J. Duwall, Sr.</b> Husband		Address <b>755 Silver Spring Ave Silver Spring, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>ACUTE MYOCARDIAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DIS.</b> DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>RHEUMATIC HEART DISEASE</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>John</b> , 19 <b>50</b> to <b>March</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>3-28</b> , 19 <b>67</b> , and that death occurred at <b>8 AM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>Bernard A. Fitzgerald</b>		22b. DATE SIGNED <b>3-29-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>BERNARD A. FITZGERALD</b>		22d. ADDRESS <b>217 Univ. BLVD E, SIL. SP., Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>April 1, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Rockville, Maryland</b>
24. FUNERAL DIRECTOR <b>Thomas J. Warner E. Pumphrey, Inc.</b>		25a. RECEIVED BY REGISTRAR <b>APR 3 1967</b>	
ADDRESS <b>8434 Georgia Avenue Silver Spring, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03787

## CERTIFICATE OF DEATH

03783

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN TB <b>35 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>14716 New Hampshire Ave.</b>		d. STREET ADDRESS <b>14716 New Hampshire Ave.</b>	
3 NAME OF DECEASED (Type or print) <b>Erma Ethel Dwyer</b>		4. DATE OF DEATH Month <b>3</b> Day <b>13</b> Year <b>1967</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>8/9/90</b>
9 AGE (In years last birthday) <b>76</b> yrs.		10 IF UNDER 1 YEAR Months <b>3</b> Days <b>13</b> Hours <b>67</b> M.n.	11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Cornelius Leizear</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth Bryan</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No None</b>	
16 SOCIAL SECURITY NO <b>214-03-9766</b>		17. INFORMANT <b>William Dwyer</b> Address <b>14716 N. H. Ave.</b> <b>Montgomery, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>COGESTIVE HEART FAILURE</b> DUE TO <b>ISCHEMIC HEART DISEASE</b> DUE TO <b>ARTERIOSELEPTIC HEART DISEASE</b> DUE TO <b>YES</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HYPERTENSION: OLD MYOCARDIAL INFARCT</b>			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>2-3 WKS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (was hospital) attended the deceased from <b>August</b> , 19 <b>66</b> , to <b>March 13</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>March 13</b> , 19 <b>67</b> , and that death occurred at <b>4P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Donald R. Lewis</b>		22b. DATE SIGNED <b>14 Mar 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Donald R. Lewis</b>		22d. ADDRESS <b>Medical Center, Olney, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar 17, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Colesville Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colesville, Maryland</b>	
24. FUNERAL DIRECTOR <b>John B. Thomas</b> <b>Warner E. Humphrey, Inc. Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 16 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>John B. Thomas</b>		25c. REGISTRAR'S SIGNATURE <b>John B. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

MONTGOMERY STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03788		MEDICAL EXAMINER'S CERTIFICATE OF DEATH				03784			
1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Montgomery</b>				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c LENGTH OF STAY IN 1b <b>2 hrs.</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> 15-1				
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>					d STREET ADDRESS <b>11805 Greenleaf Ave</b>			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Eisenberg</b> Last <b>Eisenberg</b>					4 DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>19 67</b>				
5 SEX <b>Male</b>		6 COLOR OR RACE <b>Cauc</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>4 August 1910</b>		9 AGE (In years last birthday) <b>56</b> yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>				10b KIND OF BUSINESS OR INDUSTRY <b>MEDICAL</b>		11 BIRTHPLACE (State or foreign country) <b>New York</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Louis Eisenberg</b>					14 MOTHER'S M A DEN NAME <b>Mary Kapitza</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b>				16 SOCIAL SECURITY NO <b>UNKNOWN</b>		17 INFORMANT <b>Catherine M. Eisenberg</b> <b>11805 Greenleaf Ave. Rockville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4201</b> <b>Coronary Thrombosis</b> <b>Acute</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardio Vascular Disease</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>2 hr.</b>  <b>years</b>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)					
20c TIME OF INJURY Month, Day, Year Hour o m <b>Mar 13 19 67</b> p m				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) <b>Naval Hospital</b>		20f (City or town) (County) (State) <b>Bethesda Montgomery Md</b>	
21. I certify that I took charge of the remains described above, had an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>John G. Ball</b> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>John G. Ball M.D. Montgomery Co.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>3/13/67</b>				
					Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL, SPECIAL		23b DATE THEREOF <b>3-16-1967</b>		23c NAME OF CEMETERY OR CREMATORY <b>Alexandria National Cemetery</b>			23d LOCATION (City or town) (County) (State) <b>Alexandria, Va.</b>		
24. FUNERAL DIRECTOR <b>W. W. Chambers Co. 1400 Chapin St., N.W. Washington, D.C.</b>					25a REC'D BY REGISTRAR <b>MAR 20 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		





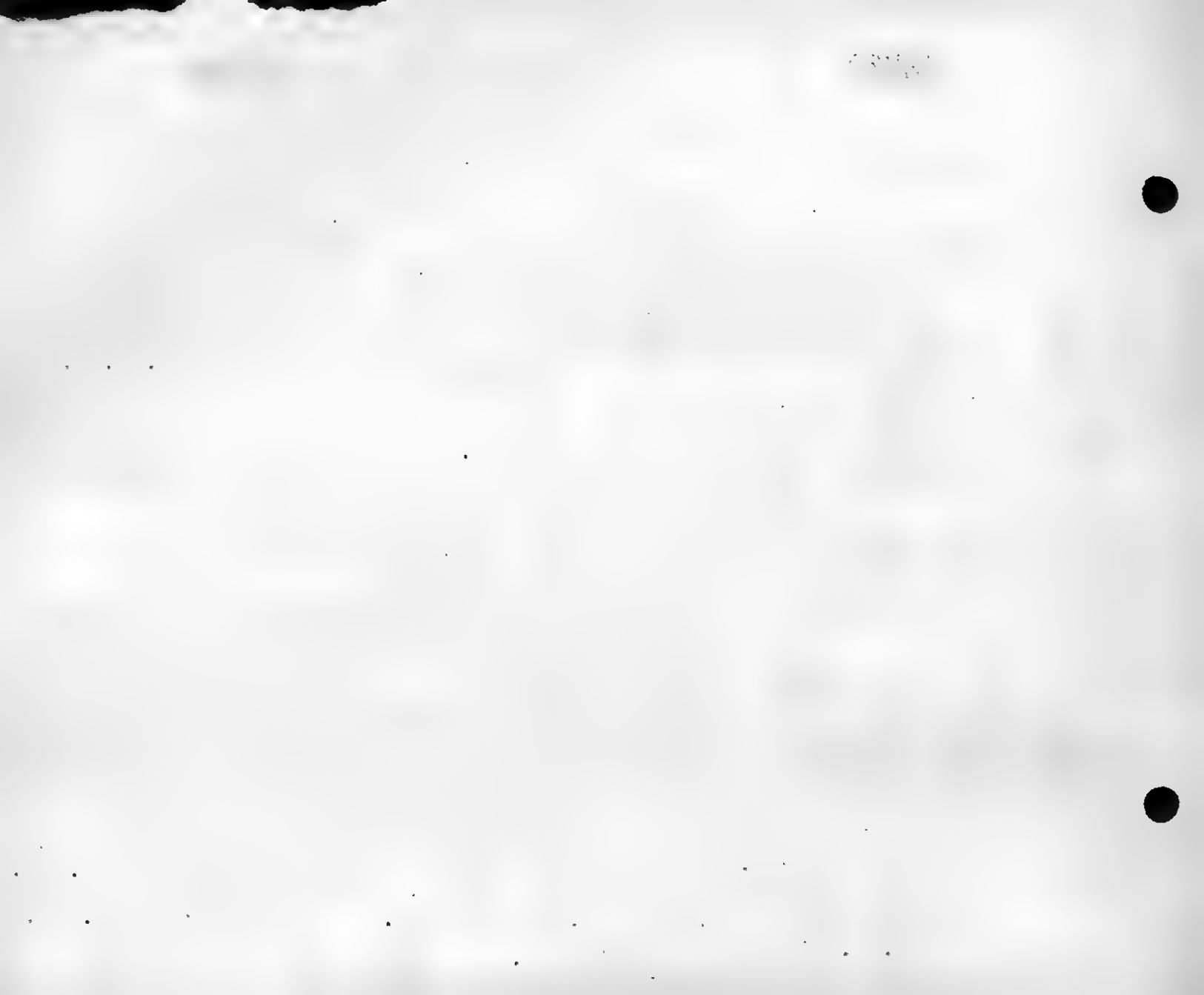
03789

CERTIFICATE OF DEATH

03785

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Colonial Villa Nursing Home</b>		d. STREET ADDRESS <b>10602 Woodsdale Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Mae</b> Middle <b>Eppley</b> Last <b>Eppley</b>		4. DATE OF DEATH Month <b>March</b> Day <b>28</b> Year <b>19 67</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/7/1880</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. F UNDER 1 Y. AR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Frostburg, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Theodore Gunnet</b>		14. MOTHER'S MAIDEN NAME <b>Annie Cosgrove</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Rev. Ann Sanderfer (same as above)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>20 yrs</b>		INTERVA. BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 29, 1961</b> , to <b>March 28, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 27, 1967</b> , and that death occurred at <b>7:25 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Arthur S. Bresler</b>		22b. DATE SIGNED <b>3-28-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Arthur S. Bresler</b>		22d. ADDRESS <b>10881 Lockwood Drive Silver Spg. Md.</b>	
23a. BURIAL, CREMATON, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>March 31, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co. Md.</b>
24. FUNERAL DIRECTOR <b>The S. H. Hines Co</b>		25a. REC'D BY REGISTRAR <b>Washington, DC</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		MAR 31 1967	



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

03790

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03786

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <input checked="" type="checkbox"/> b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY in 1b <b>6 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>				d. STREET ADDRESS <b>4929 Blaine St,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harden</b> Middle <b>Hubert</b> Last <b>Evans</b>				4. DATE DEATH Month <b>Mar.</b> Day <b>13</b> Year <b>19 67</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-18-1912</b> AGE (in years last birthday) <b>54</b> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COOK</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Orangeburg, S.C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>WILLIAM EVANS</b>				14. MOTHER'S MAIDEN NAME <b>WEATHER Livingston</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <b>Dorothy Evans</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Laceration of heart due to puncture with</b> DUE TO <b>782 X</b> Conditions, if any, which gave rise to immediate cause (b) <b>sharp, pointed, instrumentality, probably</b> stating the underlying cause lost. DUE TO <b>a knife.</b> (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <b>Deceased stabbed in chest and abdomen with a sharp instrument.</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>10:00</b> p.m. <b>3-12</b> 19 <b>67</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Norbeck Montg. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Belden R. Read M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <b>3/13/1967</b>	
EXAMINER'S NAME (Type) <b>BELDEN R. READ M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, county or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>3/17/67</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Alexandria National</b>		23d. LOCATION (City or town) (County) (State) <b>ALEXANDRIA, VA.</b>	
24. FUNERAL DIRECTOR <b>Brown + Ransom F.H. Inc.</b>				25a. REC'D BY REGISTRAR <b>MAR 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



03791

## CERTIFICATE OF DEATH

03787

1 PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if instituton Residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c LENGTH OF STAY IN 1b <u>20 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>1711 Cody Drive</u>	
3 NAME OF DECEASED (Type or print) <u>John Henry Evans</u>		4 DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>19 67</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> <del>Never</del> <del>Married</del> <del>Widowed</del>	8. DATE OF BIRTH <u>August 10, 1901</u>
9 AGE (In years last birthday) yrs. <u>65</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during mos of working life, even if retired) <u>Meat Cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Market Center</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baskerville, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wesley Evans</u>		14. MOTHER'S MAIDEN NAME <u>Margaret C. Newman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-07-3155</u>	
17. INFORMANT <u>Margaret C. Evans</u>		Address <u>1711 Cody Drive Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> DUE TO (b) <u>Cerebral hemorrhage</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Feb 12, 1967</u> , to <u>Mar 5, 1967</u> , that (I) (we) lost the deceased alive on <u>Mar 5, 1967</u> , and that death occurred at <u>8:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edward J. Richards</u> M.D.		22b. DATE SIGNED <u>3-6-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward J. Richards</u>		22d. ADDRESS <u>10110 Georgia Avenue, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 8, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>John E. Thomas</u> <u>Warner E. Humphrey, Inc.</u>		25a. RECD BY REGISTRAR <u>Mar 8 1967</u>	
ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

03792

03788

1 PLACE OF DEATH a COUNTY <b>MONTGOMERY</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution, include date of admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>				c LENGTH OF STAY IN 1b <b>45 days</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SAN. &amp; HOSPITAL</b>				e STREET ADDRESS <b>9900 gardiner AVE,</b>			
3 NAME OF <b>EFFIE ELNORA EVELAND</b> (Type or print) First Middle Last				4 DATE OF DEATH <b>3</b> Month <b>24</b> Day <b>19</b> Year <b>67</b>			
5 SEX <b>FE</b>		6 COLOR OR RACE <b>WH</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-2-75</b> 91 yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HSW</b>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Amos HESS</b>				14 MOTHER'S MAIDEN NAME <b>MARTHA HESS (same)</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16 SOCIAL SECURITY NO		17 INFORMANT <b>Hospital Records</b> Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO <b>PULMONARY EDEMA</b> (b) <b>CORONARY ARTERY DISCEASE</b> (c) Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last							INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b> <b>Years</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic pyelonephritis, Pneumonia, Anemia</b>							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 7, 1967</b> to <b>Mar 24, 1967</b> , that (I) (we) lost saw the deceased alive on <b>Mar 24 1967</b> , and that death occurred at <b>8:54 PM</b> , from causes and on the date stated above							
22a SIGNATURE <b>John L. Ford</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED <b>MAR 24 1967</b>	
22c PHYSICIAN'S NAME (Type) <b>JOHN L. FORD</b>				22d ADDRESS <b>31 UNIVERSITY BLVD E SILVER SPRING, MD</b>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
<b>Burial</b>		<b>3/27/1967</b>		<b>St James Cemetery</b>		<b>Fishing Creek Township, Penna.</b>	
24 FUNERAL DIRECTOR <b>Charles Walters, 254 Carroll St NW, DC</b>				25a REC'D BY REGISTRAR <b>MAR 28 1967</b>		25b REGISTRAR SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





03793

## CERTIFICATE OF DEATH

03789

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton Silver Spring</b> c. LENGTH OF STAY IN 1b <b>1 1/2 mos.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp'tal, give street address) <b>University Nursing Home</b>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> d. STREET ADDRESS <b>8313 Flower Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Grace Evangeline Ewy</b>				4. DATE OF DEATH Month <b>Mar</b> Day <b>28</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caus.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/5/1884</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public Schools</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New Ulm, Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jorgen Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Anna Roland</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no None</b>		16. SOCIAL SECURITY NO. <b>214-34-7092</b>		17. INFORMANT <b>Constance Ewy-Takoma Park, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4570</b> DUE TO <b>arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>arteriosclerosis</b> DUE TO <b>arteriosclerosis</b> (c) <b>arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arteriosclerosis arteriosclerosis</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 15</b> , 19 <b>67</b> , to <b>3/28</b> , 19 <b>67</b> ; that (I) (we) lost saw the deceased alive on <b>3/24</b> , 19 <b>67</b> , and that death occurred at <b>9:10 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Charles Wolohan, M.D.</b>				22b. DATE SIGNED <b>3-28-67</b>		22c. PHYSICIAN'S NAME (Type) <b>Charles Wolohan, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar 31, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR <b>John B. Thomas Warner E. Pumphrey, Inc.</b>				25a. REC'D BY REGISTRAR <b>MAR 31 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03794

## CERTIFICATE OF DEATH

03790

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~death~~ papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>15 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>7773 Emerson Rd.</u>	
3 NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>H.</u> Last <u>FAASEN</u>		4. DATE OF DEATH Month <u>MAR</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/22/05</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Army Air Force</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Holland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>JOHN FAASEN</u>		14 MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>164-07-1093</u>	
17 INFORMANT <u>MARY FAASEN</u> Address <u>SAME AS #2</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4201 DUE TO (b) <u>arteriosclerotic coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>postoperative wound, allergic reaction, embolism</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5:00 pm</u> , 19 <u>67</u> , to <u>2:19 pm</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>20 pm</u> , 19 <u>67</u> , and that death occurred at <u>3:29 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph F. Schanno</u> M.D.		22b. DATE SIGNED <u>3-21-1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH F. SCHANNO M.D.</u>		22d. ADDRESS <u>828 1/2 Wisconsin Ave Bldg. 1m 14</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-24-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort LINCOLN CEM</u>	23d. LOCATION (City or Town) (County) (State) <u>BLADENSBURG, MARYLAND</u>
24. FUNERAL DIRECTOR <u>W.W. Chambers &amp; Riverdale, Md</u>		25a. REC'D BY REGISTRAR <u>MAR 23 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE  
HEALTH DEPT

03795

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03791

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>9 months</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3004 Findley St. Road</u>				d. STREET ADDRESS <u>3004 Findley St. Road</u>			
3 NAME OF DECEASED (Type or print) <u>Charles Thomas Farrell</u>				4 DATE OF DEATH <u>3</u> <u>17</u> <u>1967</u>			
5 SEX <u>male</u>		6 COLOR OR RACE <u>white</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8 DATE OF BIRTH <u>6-13-23</u> <u>43</u> yrs	
9. AGE (In years lost birthday) <u>43</u> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber helper</u>				10b KIND OF BUSINESS OR INDUSTRY <u>plumbing</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Farrell</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Hurd</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>216-16-996544</u>		17. INFORMANT <u>William F. Farrell</u> Address <u>3004 Findley Road Silver Spring, Md.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia due to obstruction of pharynx</u> <u>722.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>with blood from nasal fracture</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Deceased, an epileptic, fell, fractured nose and hemorrhaged</u>			
20c. TIME OF INJURY Month, Day, Year <u>0:00</u> <u>3-17</u> <u>1967</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Silver Spring</u> (County) <u>Montg</u> (State) <u>Md.</u>							
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.				22. DATE SIGNED <u>3/17/1967</u>			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>				DEPUTY MEDICAL EXAMINER <u>[Signature]</u> Address (City, county, and state)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar 21, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City or Town) <u>Silver Spring, Maryland</u> (County) (State)	
24. FUNERAL DIRECTOR <u>John S. Thomas</u> <u>4434 Georgia Avenue</u> <u>Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>John S. Thomas</u> <u>22</u> <u>1967</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03796

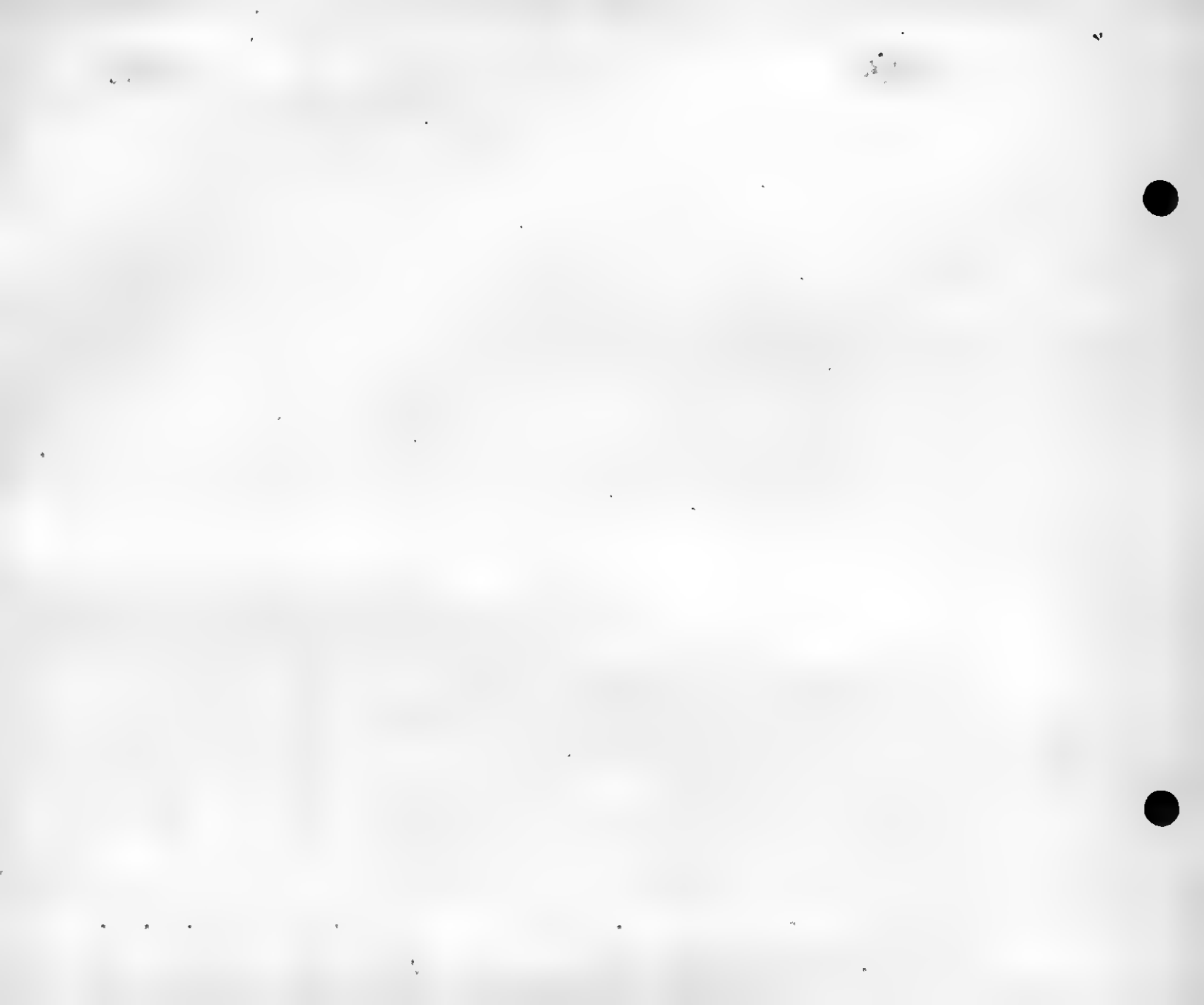
## CERTIFICATE OF DEATH

03792

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>9 mos</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>CHEVY CHASE NURSING AND CONVALESCENT CENTER 5524 SOUTHWICK ST.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>PHILIP</u> Middle <u>W.</u> Last <u>FAUNCE</u>		4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7 NOVEMBER 86</u>
9. AGE (In years last birthday) <u>80 yrs</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret. red) <u>Map-Mounter-Photographer, Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PHILIP Pote Faunce</u>		14. MOTHER'S MAIDEN NAME <u>Alice Carroll</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Wife</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> <u>11201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>coronary atherosclerosis</u> DUE TO (c) <u>2 hours</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Pulmonary Emphysema</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 19 <u>65</u> to <u>1967</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>14 Jan</u> 19 <u>66</u> , and that death occurred at <u>1:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>SEAN J. DAUM</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-23-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>SEAN J. DAUM</u>		22d. ADDRESS <u>4077 BATTERY LANE BETHESDA MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-27-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03797

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03793

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>	c. LENGTH OF STAY IN b. <u>21 HRS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK 1-7</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>WASHINGTON SAN &amp; HOSP.</u>		d. STREET ADDRESS <u>7501 FLOWER AVE</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>MR. PAUL</u> First Middle Last <u>NONE</u> <u>FEEDBACK</u>		4. DATE OF DEATH Month <u>3</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/11/06</u>
9. AGE (In years lost birthday) <u>60</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CAB DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CAB DRIVER</u>	11. BIRTHPLACE (State or foreign country) <u>OKLAHOMA</u>
12. CITIZEN OF WHAT COUNTRY? <u>AMER.</u>		13. FATHER'S NAME <u>ISSAC FEEBACK</u>	
14. MOTHER'S MAIDEN NAME <u>KITURA WILLIAMS</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>MARINES 300</u>	
16. SOCIAL SECURITY NO. <u>215-26-0267</u>		17. INFORMANT <u>PT C. Hart</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Intra-Cerebral Hemorrhage</u> DUE TO (b) <u>351A</u> DUE TO (c) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last</u>			INTERVAL BETWEEN ONSET AND DEATH <u>22 hr.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3/8/67</u>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL, Spec. Inv. <u>Burial</u>	23b. DATE THEREOF <u>Mar. 11, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor Md. Md.</u>
24. FUNERAL DIRECTOR <u>Walter Waters</u>		25a. DATE <u>MAR 13 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M S-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03798						03794					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
MONTGOMERY			MARYLAND			NEW JERSEY			b. COUNTY		
KENSINGTON			KENSINGTON NURSING HOME			RIDGEFIELD PARK			18 CEDAR STREET		
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
RACHAEL						FELLMAN March 15 1967					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
FEMALE		WHITE				1878		88 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
HOUSEWIFE								RUSSIA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
MORRIS KLUGER				UNKNOWN				USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
NO								DAUGHTER			
				MRS. EDNA MAURER				-3000 39th St., NW			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST											
DUE TO											
Conditions, if any, which gave rise to immediate cause (b) ASCVD											
(c) SCENILITH											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
DECEASED DUE TO DECUBITUS ULCERS - PNEUMONIA											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from July 1967, to 15 March 1967, that (I) (we) last saw the deceased alive on 15 March 1967, and that death occurred at 2 PM, from the causes and on the date stated above.											
22a. SIGNATURE											
Horace W. Bernton M.D.											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) HORACE W. BERNTON, M.D.											
22d. ADDRESS											
4743 BRADLEY BLVD., CHEVY CHASE, MD											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
BURIAL											
23b. DATE THEREOF											
3-17-67											
23c. NAME OF CEMETERY OR CREMATORY											
MT. MORIAH CEMETERY											
23d. LOCATION (City, town or county) (State)											
FAIRVIEW, NEW JERSEY											
24. FUNERAL DIRECTOR'S SIGNATURE											
BERNARD DANZANSKY AND SONS WASHINGTON DC											
25a. REC'D BY REGISTRAR											
MAR 20 1967											
25b. REGISTRAR'S SIGNATURE											
J. Charles Judge											



03799

## CERTIFICATE OF DEATH

03795

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seabrook</u>		c. LENGTH OF STAY IN 1b <u>24 hrs. 40 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
3 NAME OF DECEASED (Type or print) <u>Albert M. Fick</u>		4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2/15/199</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>IN HARVESTER</u>	
11. BIRTHPLACE (County & State or foreign country) <u>KANSAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>707-14-7297A</u>	
17. INFORMANT <u>Mrs. Madeline Schwarz - daughter - same</u>		Address <u>2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u> <u>YEARS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-17</u> , 19 <u>67</u> , to <u>3-2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-2</u> , 19 <u>67</u> , and that death occurred at <u>3:10</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>K. D. Bucy</u>		22b. DATE SIGNED <u>3-2-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. L. Bucy</u>		22d. ADDRESS <u>809 Veir's Mill Rd Rockville Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/3/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Shady Brooke-Lutheran</u>	23d. LOCATION (City or town) (County) (State) <u>Shady Brook, Kansas</u>
24. FUNERAL DIRECTOR <u>Person heiler</u>		25a. REC'D BY REGISTRAR <u>131 Rockville Pike</u> <u>Rockville, Maryland</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 6 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03800

## CERTIFICATE OF DEATH

03796

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> c. LENGTH OF STAY IN TB <u>6 months</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>		d. STREET ADDRESS <u>4817 Creek Shore Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>ELLA</u> First <u>L.</u> Middle <u>Fisher</u> Last		<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>20</u> Year <u>1967</u>	
<b>5. SEX</b> <u>7</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIAGE STATUS</b> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3/11/1882</u>
<b>9. AGE</b> (In years last birthday) <u>85</u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New York</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S.</u>		<b>13. FATHER'S NAME</b> <u>Henry Van Hagen</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Ella Eliz Allen</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>	
<b>16. SOCIAL SECURITY NO.</b> <u>218-56-7848</u>		<b>17. INFORMANT</b> <u>Daughter</u> Address <u>Same as Item 2.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary artery occlusion (acute)</u> (b) <u>Coronary artery sclerosis</u> (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>25 months</u> <u>10+ years</u> <u>20+ years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that (I) (this hospital) attended the deceased from <u>Feb 23, 1966</u>, to <u>March 20, 1967</u>, that (I) (we) last saw the deceased alive on <u>March 19, 1967</u>, and that death occurred at <u>8:05 A.M.</u> from causes on and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>R. Stephen Hulburt</u>		<b>22b. DATE SIGNED</b> <u>March 20, 1967</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>R. STEPHEN HULBURT</u>		<b>22d. ADDRESS</b> <u>3000 Dent Place, W.W.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>3-22-67</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Parklawn Cemetery</u>	<b>23d. LOCATION (City or Town) (County) (State)</b> <u>Rockville, Maryland</u>
<b>24. FUNERAL DIRECTOR</b> <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Maryland</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAR 28 1967</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
03801		Items #5, 6 & 7						03797						
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sylvan Manor Health Care Center						d. STREET ADDRESS 4611 - 27th St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Richard			Middle B.			Last Forrest Sr.			4. DATE OF DEATH Month March		Day 27		Year 1967	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/24/1899		9. AGE (In years last birthday) 68		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Atlantic Coast RR.				11. BIRTHPLACE (County & State, or foreign country) New Hampshire				12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James L. Forrest						14. MOTHER'S MAIDEN NAME Mary M. Carrie								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>				16. SOCIAL SECURITY NO. WWI		17. INFORMANT Mrs. Alice Forrest (above address) (Wife)								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - Gangrene of R foot. DUE TO (b) - Arteriosclerotic disease of legs. DUE TO (c) - Diabetes Mellitus. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Congestive Heart Failure.										INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs. 5 years 10 years.				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1961, to March 27, 1962, that (I) (we) last saw the deceased alive on 3/27 1962, and that death occurred at 2 P. M. from the causes and on the date stated above.														
22a. SIGNATURE Samuel Dessoff						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/27/67				
22c. PHYSICIAN'S NAME (Type) SAMUEL DESSOFF						22d. ADDRESS 1302-18th N.W. Wash. D.C.								
23a. BURIAL, CREMATION, REBURY (Indicate)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)				
Cremation				3/29/67		Fort Lincoln Cemetery				Colmar Manor, Md.				
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.						ADDRESS Mt. Rainier, Maryland		25a. REC'D BY REGISTRAR MAR 30 1967		25b. REGISTRAR'S SIGNATURE [Signature]				



03802

CERTIFICATE OF DEATH

03798

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
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Cleared - Dep Medical Examiner 3/30/67

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>MONTGOMERY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		d. STREET ADDRESS <b>1220 EAST WEST HWY.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>AMALIA</b>		First		Middle		Last <b>FRAGNAL</b>		4. DATE OF DEATH Month <b>3</b> Day <b>30</b> Year <b>1967</b>		5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. AGE (In years last birthday) <b>79</b> yrs		9. DATE OF BIRTH <b>10-10-87</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>AUSTRIA-HUNGARY</b>		12. CITIZEN OF WHAT COUNTRY? <b>ITALY</b>		13. FATHER'S NAME <b>FRANK ADRARIO</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE POLCICH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO		17. INFORMANT <b>DANIEL FRAGNAL</b>		Address <b>SAME AS #3</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b> <b>200X</b> DUE TO (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> DUE TO (c) <b>DIABETES MELLITUS (IN PART)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b>		19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										21. I certify that (I) (this hospital) attended the deceased from <b>2/15</b> , 19 <b>67</b> , to <b>3/30</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3/30</b> , 19 <b>67</b> , and that death occurred at <b>3:45</b> AM, from causes and on the date stated above			
22a. SIGNATURE <b>Lawrence D. Marcus</b>		22b. DATE SIGNED <b>3/30/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Lawrence D. Marcus, M.D.</b>		22d. ADDRESS <b>808 Pershing Dr., Silver Spring, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-1-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION (City or town) (County) (State) <b>Silver Spring, Md.</b>	
24. FUNERAL DIRECTOR <b>Collins Funeral Home</b>		25a. REC'D BY REGISTRAR <b>APR 3 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. NAME OF REGISTRAR <b>Charles Judge</b>		25d. ADDRESS <b>3821 14th St. N.W. D.C.</b>		25e. DATE <b>APR 3 1967</b>		25f. SIGNATURE <b>Charles Judge</b>		25g. ADDRESS <b>3821 14th St. N.W. D.C.</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03803				CERTIFICATE OF DEATH				03799			
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GERMANTOWN</u>				c. LENGTH OF STAY IN 1b <u>1 year 8 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				15-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Marylander Home of Rest, Inc.</u>						d. STREET ADDRESS <u>RFD #3, Box 349</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROSA</u> Middle <u>MINNICH</u> Last <u>FRIDAY</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>12</u> Year <u>1967</u>								
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/3/1874</u>		9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>CHRISTE, PA.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>FRANK MINNICH</u>						14. MOTHER'S MAIDEN NAME <u>KATHERINE BLOSER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>215-36-2891</u>		17. INFORMANT <u>Neice Edna F. Eader</u>		2814 Linden Lane Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral</u> DUE TO (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>15 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) <u>James P. Kerr</u> attended the deceased from <u>7/13</u> , 19 <u>65</u> , to <u>3/12</u> , 19 <u>67</u> , that (I) <u>last</u> saw the deceased alive on <u>3/9</u> , 19 <u>67</u> , and that death occurred at <u>4 A.M.</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>James P. Kerr</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/12/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>JAMES P. KERR M.D.</u>						22d. ADDRESS <u>JAMARCUS, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>3-13-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>				23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>			
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>						25a. REC'D BY REGISTRAR <u>16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove calling papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03804					03800						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <b>Montgomery</b> MARYLAND					a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>						
c. LENGTH OF STAY IN 1b <b>47 Years</b>					d. STREET ADDRESS <b>7108 Cedar Avenue</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7108 Cedar Avenue</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
<b>ASENATH</b>			<b>SHELTON</b>			<b>FRYE</b>			<b>March 11, 1967</b>		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<b>Female</b>		<b>White</b>		<b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		<b>December 28, 1887</b>		<b>79 yrs.</b>		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Raleigh Shelton</b>					14. MOTHER'S MAIDEN NAME <b>Jane Limerick</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Jane F. Morgan</b>			Address <b>Same as # 2 above.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute cardiac failure</b> DUE TO (b) <b>chronic arthritis</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>Indefinite</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>July 7, 1965</b> to <b>Mar. 11, 1967</b> , that (I) (we) last saw the deceased alive on <b>Mar. 11, 1967</b> , and that death occurred at <b>8:15 P.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>A. B. Little</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Mar. 11, 1967</b>				
22c. PHYSICIAN'S NAME (Type) <b>A. B. LITTLE MD</b>					22d. ADDRESS <b>6911 5th &amp; New York Ave. DC</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>3/ /1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>George Washington</b>			23d. LOCATION (City, town or county) (State) <b>Adelphi, Maryland</b>			
24. FUNERAL DIRECTOR <b>J. Arthur Walter</b>					25a. REC'D BY REGISTRAR <b>Mar 15 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				





CORNER NOTIFIED AND RELEASED TO US OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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M

CLEARED BY MEDICAL EXAMINER - DR. BALL

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03805

## CERTIFICATE OF DEATH

03801

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution. Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Essex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN TB <u>1 day</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Montclair</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>59 Grandview Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Laurence U. Fullem</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>March 3, 19 67</u>		<b>5. SEX</b> <u>Male</u>	
<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>June 20, 1898</u>		<b>9. AGE</b> (In years last birthday) <u>68</u> yrs.	<b>10. UNDER 1 YEAR</b> Months Days Hours Min	<b>11. UNDER 24 HRS.</b> Hours Min	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired accountant</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Licht Architect</u>		<b>11. BIRTHPLACE</b> (County & State or foreign country) <u>New Jersey</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Unknown</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Yes</u>		<b>17. INFORMANT</b> <u>Moriarty Funeral Home</u> <sup>Address</sup> <u>16 Park St. Montclair, New Jersey</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR THROMBOSIS</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 DAYS</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	<b>20g. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from <u>2 MARCH, 19 67</u> to <u>3 MARCH 19 67</u>, that (I) (we) last saw the deceased alive on <u>24 MARCH 19 67</u>, and that death occurred at <u>1:55</u> M, from causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>[Signature]</u>				<b>22b. DATE SIGNED</b> <u>3 March 67</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Walter Goozh, M.D.</u>	
<b>22d. ADDRESS</b> <u>2390 Glenmont Circle, Wheaton, Maryland</u>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Trans-burial</u>		<b>23b. DATE THEREOF</b> <u>March 6, 1967</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Immaculate Conception Cem. Upper Montclair, N. J.</u>		<b>23d. LOCATION (City or Town)</b> (County) (State)		
<b>24. FUNERAL DIRECTOR</b> <u>Glen Carter</u> <u>Warner E. Humphrey, Inc. Silver Spring, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAR 8 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>			



03806

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

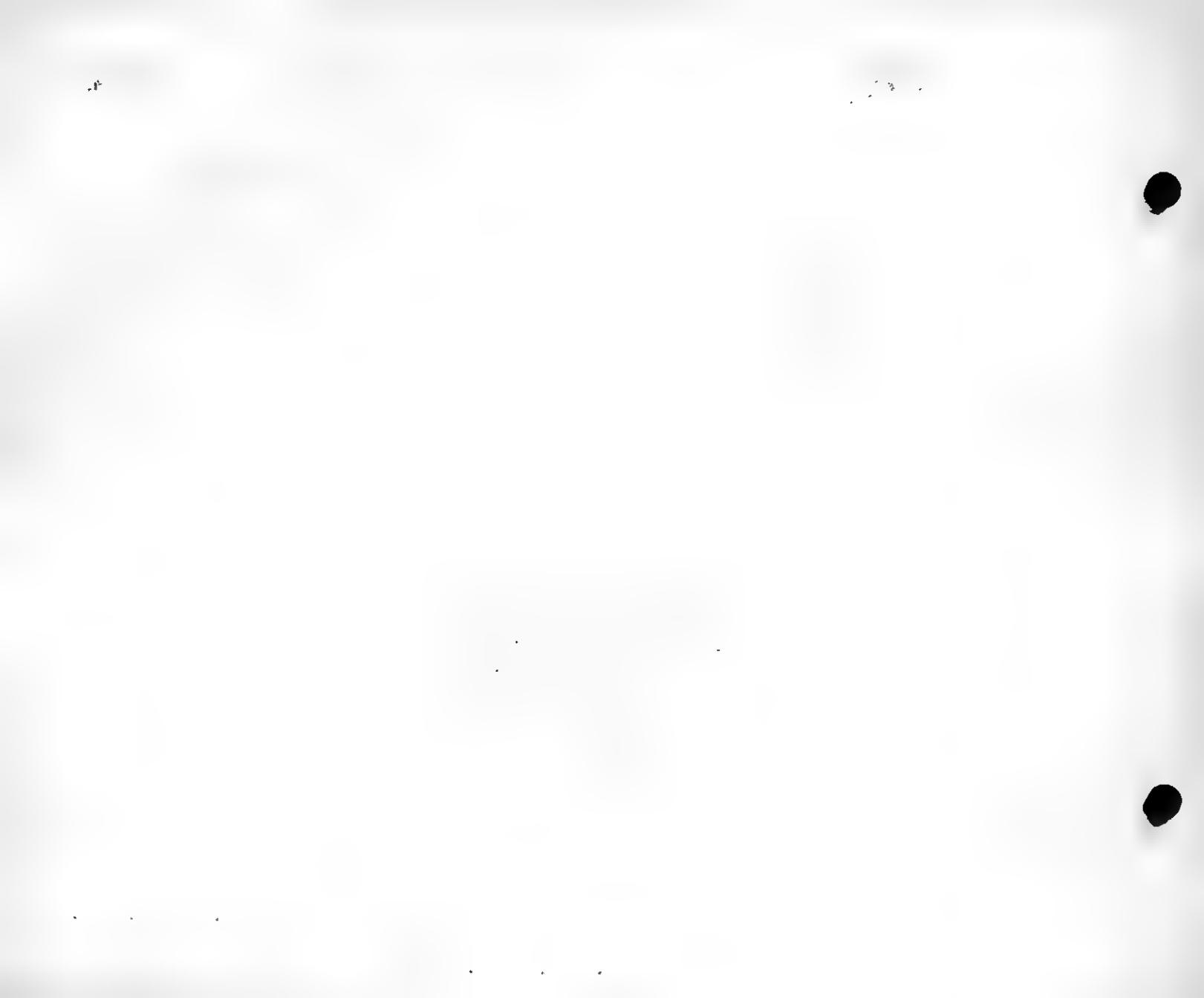
03802

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY, Silver Spring, MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived, if inst. in Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RJRAT and give nearest town) <b>Silver Spring, Maryland</b>		c. LENGTH OF STAY IN 1b <b>1 hr</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>1220 Blair Mill Road</b>	
3 NAME OF DECEASED (Type or print) First <b>Abe</b> Middle <b>H</b> Last <b>Furr</b>		4 DATE OF DEATH Month <b>3</b> Day <b>30</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/10/00</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>30</b> Hours <b>19</b> Min <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gov</b>	
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Azreal Furr</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Turkeniecz</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes 1918-19</b>		16. SOCIAL SECURITY NO. <b>579-60-3166</b>	
17. INFORMANT <b>sister</b> <b>Mrs Rose Rogow</b>		1220 Blair Mill Rd <b>Silver Spring, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Acute Coronary Insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Coronary Artery Heart Disease</b> (b) <b>Coronary Artery Heart Disease</b> DUE TO <b>Coronary Artery Heart Disease</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary Emphysema</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Balden R. Reap</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BALDEN R. REAP, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, City, County or town)		Address (Street, City, County or town)	
22. DATE SIGNED <b>3/30/1967</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>3/31/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ohev, Sholom-Talmud Torah Cem., Wash.D.C.</b>		23d. LOCATION (City or Town) (County) (State) <b>Wash.D.C.</b>	
24. FUNERAL DIRECTOR <b>Bernard Danzansky &amp; Sons</b>		ADDRESS <b>3501-14th St.N.W.Wash.D.C.</b>	
25a. REC'D BY REGISTRAR <b>APR 3 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



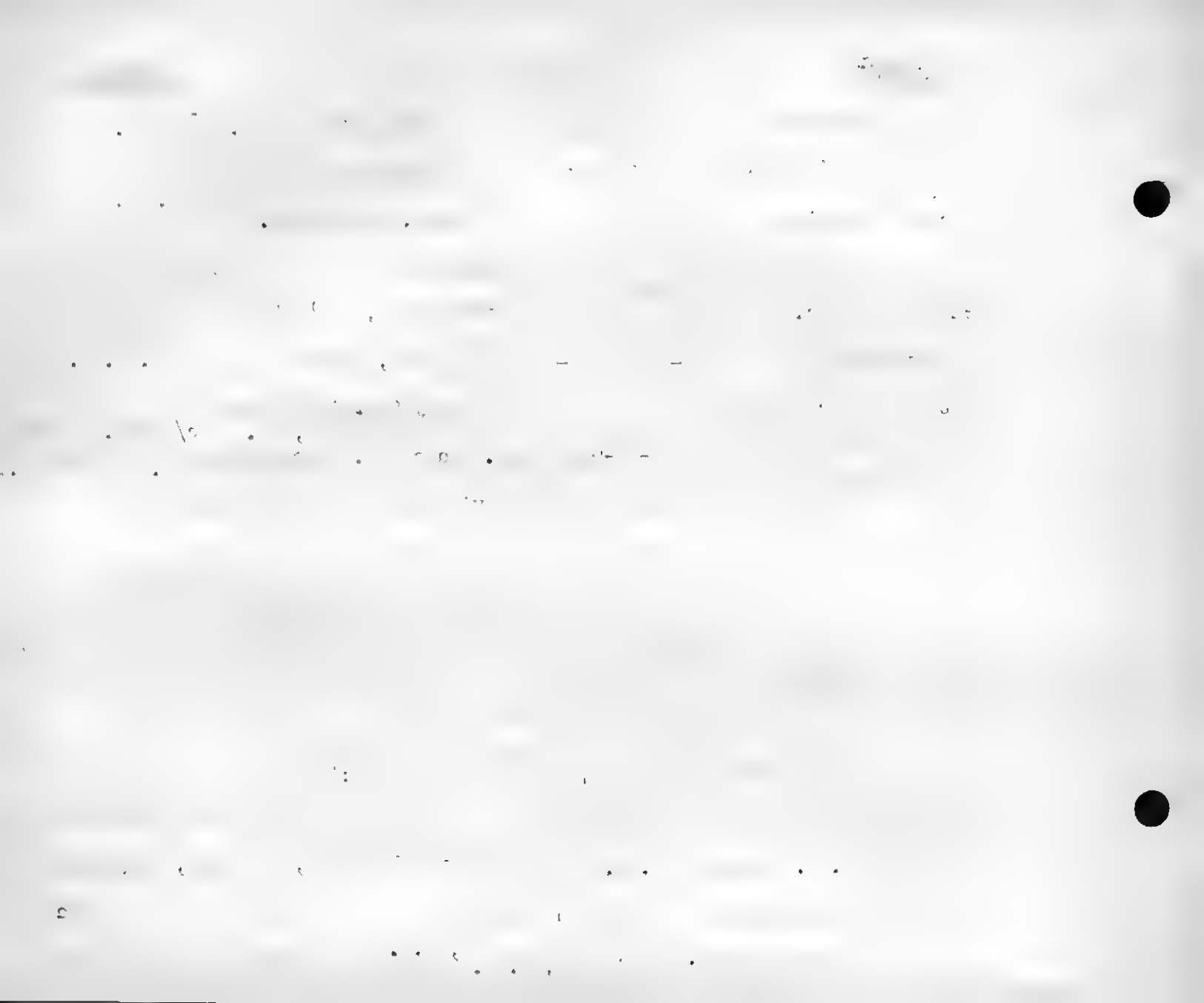
CERTIFICATE OF DEATH

03807

03803

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Missouri</b> <b>Dist. of Col.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>32 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. STREET ADDRESS <b>2801 Quebec St. NW.</b> <b>960 S. Fremont St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Charlotte</b> Middle <b>Emma</b> Last <b>GALBRAITH</b>		4. DATE OF DEATH Month <b>March</b> Day <b>19</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 18, 1914</b> 52 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Toronto, Canada</b>	
13. FATHER'S NAME <b>John Fredic Kew Mens</b>		14. MOTHER'S MAIDEN NAME <b>Fanny Georgine Thompson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>482-28-9858</b>	
17. INFORMANT <b>Springfield, Mo.</b> Address <b>c/o Mrs. Charles Gray</b> <b>Mr. Francis L. Galbraith</b> <b>960 S. Fremont St.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of breast with widespread metastases</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 14, 1967</b> to <b>March 19, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 19, 1967</b> , and that death occurred at <b>2:25 A.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Albert C. Ashworth</i>		22b. DATE SIGNED <b>19 March 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. E. Ashworth M. D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL <b>Removal</b>	23b. DATE THEREOF <b>3-21-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Toronto Canada</b>
24. FUNERAL DIRECTOR <b>Joseph Gawler &amp; Sons Inc.</b>		25a. REC'D BY REGISTRAR <b>W. W. Judge</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. DATE <b>MAR 23 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT

03808

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03804

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institutional residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Montgomery</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c LENGTH OF STAY IN lb <b>22 hours</b>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d STREET ADDRESS <b>RFD #2 Box 265</b>	e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last <b>William A. Gallagher</b>		4. DATE OF DEATH Month Day Year <b>March 17, 1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>8 / 30 / 1900</b>
9 AGE (In years last birthday) <b>66 yrs</b>		10 IF UNDER 1 YEAR Months Days Hours M. n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney-retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William J. Gallagher</b>		14 MOTHER'S MAIDEN NAME <b>Nano C. Bresnan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>578-44-1124</b>	
17 INFORMANT <b>Margaret Ozburn Gallagher-same as #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Multiple skull fractures with</b> <b>900.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>intracranial hemorrhage due to fall</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1</b>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Deceased fell down stairway at home</b>	
20c. TIME OF INJURY Month, Day, Year Hour am <b>4:30 PM 3-16 19 67</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <b>home</b>	20f. (City or town) (County) (State) <b>Gaithersburg Montg. Md.</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Reap M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>3/17/1967</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-20-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>	23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Maryland</b>
24 FUNERAL DIRECTOR <b>F. J. Collins</b>		ADDRESS <b>Francis J. Collins 3821-14th St. NW Wash DC</b>	
25a. REC'D BY REGISTRAR <b>MAR 21 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03809

## CERTIFICATE OF DEATH

03805

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Pinellas</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>36 hours</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Petersburg</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>1725 66th Ave. North</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William James Gamble</u>		4. DATE OF DEATH Month Day Year <u>March 31 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1897</u>
9. AGE (In years last birthday) yrs <u>69</u>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lithographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Gamble</u>		14. MOTHER'S MAIDEN NAME <u>Annie Wagner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>216-44-4485</u>	
17. INFORMANT <u>Lelia Gamble - Wife - Same As #9</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of tail of pancreas with</u> 157X DUE TO (b) <u>metastasis to lungs, liver, adrenals and</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>abdomen</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1967</u> , to <u>March 31, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 31, 1967</u> , and that death occurred at <u>5:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Aaron H. Traum</u>		22b. DATE SIGNED <u>April 1, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Aaron H. Traum</u>		22d. ADDRESS <u>827 Georgia Ave. Silver Spring, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 4, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Southlawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Coshocton, Ohio</u>
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03810

## CERTIFICATE OF DEATH

03806

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>33 days</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>12650 Heming Lane</b>	
3 NAME OF DECEASED (Type or print) First <b>Katherine</b> Middle <b>Gibney</b> Last <b>GENTZEL</b>		4 DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Nov. 10, 1925</b>
9 AGE (In years last birthday) <b>41</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Carbondale, Pennsylvania</b>
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James Gibney</b>	
14. MOTHER'S MAIDEN NAME <b>Helen Coggins</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16 SOCIAL SECURITY NO		17. INFORMANT <b>Heming Lane</b> Address <b>Bowie, Md.</b> <b>Major Charles R. Gentzel, USAF, 12650</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Diffuse carcinomatosis secondary to intraductal carcinoma right breast</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o.m.</b> <b>19</b> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that <del>as</del> (this hospital) attended the deceased from <b>Feb. 11, 19 67</b> , to <b>Mar. 15, 1967</b> , that <del>at</del> (we) last saw the deceased alive on <b>Mar. 15, 1967</b> , and that death occurred at <b>332A M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Francis D. Keenan, Jr.</i> M.D.		22b. DATE SIGNED <b>16 Mar. 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Francis D. Keenan, Jr., M. D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a BURIAL, CREMATION, or other disposal	23b. DATE THEREOF <b>3/20/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington Va.</b>
24 FUNERAL DIRECTOR <b>Nalley's Funeral Home</b> <b>3200 Rhode Island Ave., Mt. Ranier, Md.</b>		25a REC'D BY REGISTRAR DATE <b>MAR 21 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



03811

## CERTIFICATE OF DEATH

03807

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Wheaton</b> c LENGTH OF STAY IN lb <b>6 1/2 mos.</b> d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>University Nursing Home</b>		2 USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a STATE <b>FLORIDA</b> b COUNTY <b>WALTON</b> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DE FUNIAK SPRINGS</b> d STREET ADDRESS <b>4</b> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) (Judge) Donald Stuart Gillis First Middle Last 4 DATE OF DEATH Month Day Year <b>3 26 19 67</b>		5 SEX <b>Male</b> 6 COLOR OR RACE <b>Caus.</b> 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8 DATE OF BIRTH <b>11/5/1879</b> 9 AGE (in years last birthday) <b>87 yrs</b> 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Circuit Judge</b> 10b KIND OF BUSINESS OR INDUSTRY <b>Law</b> 11 BIRTHPLACE (County & State, or foreign country) <b>Freeport, Florida</b> 12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Dr. Angus M. Gillis</b> 14 MOTHER'S MAIDEN NAME <b>Nancy McLean</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No None</b> 16 SOCIAL SECURITY NO. <b>261-78-0101A</b> 17 INFORMANT <b>Mrs. Robt. Perry-Silver Spring, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>4221 Congestive heart failure</b> DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of tongue</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>Sept. 18, 1966</b> , to <b>March 26, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 26, 1967</b> , and that death occurred at <b>4:30 P.M.</b> , from causes and on the date stated above.			
22a SIGNATURE <b>Raymond Bradshaw</b>		22b DATE SIGNED <b>March 26, 1967</b>	
22c PHYSICIAN NAME (Type) <b>Raymond Bradshaw, M.D.</b>		22d ADDRESS <b>345 University Blvd, West, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Trans-burial</b>		23b DATE THEREOF <b>Mar 29, 1967</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Magnolia Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>De Funia Springs, Florida</b>	
24 FUNERAL DIRECTOR <b>John B. Thomas</b> <b>Warner E. Humphrey, Inc. Silver Spring, Md.</b>		25a REC'D BY REGISTRAR <b>MAR 29 1967</b>	
25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

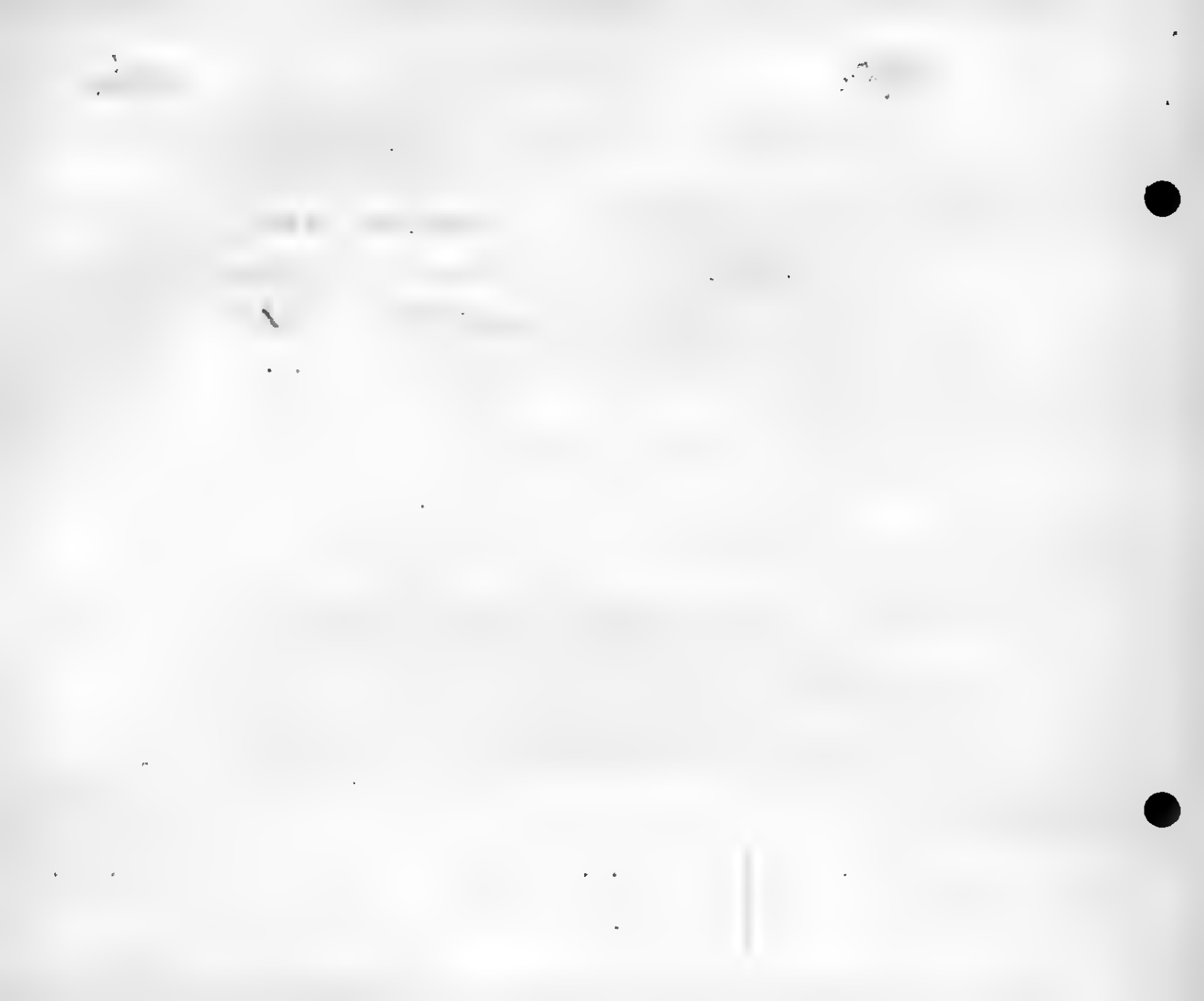
03812

CERTIFICATE OF DEATH

03809

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>8504 16th STREET</u>	
3 NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>GINS</u> Last <u>GINS</u>		4 DATE OF DEATH Month <u>MARCH</u> - Day <u>1</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10/27/05</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DISTRIBUTOR-MOTION PICTURES</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON, D.C.</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>BENNETT GINSBERG</u>		14. MOTHER'S MAIDEN NAME <u>BRINDEL TROSHINSKY</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO. <u>167 10 5391</u>	
17 INFORMANT <u>WIFE</u>		Address <u>MILDRED GINS - SEE d ABOVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lymphatic cancer</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August, 1966</u> , to <u>3/1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/1</u> , 1967, and that death occurred at <u>1:30 P.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>G. Lennard Gold</u>		22b. DATE SIGNED <u>3/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. LENNARD GOLD, M.D.</u>		22d. ADDRESS <u>8641 COLESVILLE RD., SIL. SPG. MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-3-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. LEBANON CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>HYATTSTVILLE, MARYLAND</u>
24. FUNERAL DIRECTOR <u>BERNARD DANZANSKY &amp; SONS WASHINGTON DC</u>		25a. REC'D BY REGISTRAR <u>MAR 6 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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20 M 1/66





03813

## CERTIFICATE OF DEATH

03810

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>21 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp. Ta'</u>		e. STREET ADDRESS <u>6301 W. Halbert Rd</u>	
3 NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Goldberg</u> Last <u>Goldberg</u>		4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>19 67</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-1-13</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) <u>Depty Asst Sec.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept Labor</u>	9 AGE (In years last birthday) yrs. <u>53</u>
11 BIRTHPLACE (County & State or foreign country) <u>Poland</u>		12 CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>SAM Goldberg</u>		14. MOTHER'S MAIDEN NAME <u>Esther Berensohn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Dr. Vira Goldberg - wife</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <u>260X</u> IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>atherosclerosis</u> DUE TO (c) <u>Diabetic Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3-11</u> , 19 <u>67</u> , to <u>3-12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-12</u> , 19 <u>67</u> , and that death occurred at <u>12:35 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Bernard H. Ostrow</u>		22b. DATE SIGNED <u>3-12-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD H. OSTROW</u>		22d. ADDRESS <u>8107 EASTERN AVE S.S., MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>3/13/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Gard.</u>		23d. LOCATION (City or Town) (County) (State) <u>Falls Church, Va.</u>	
24 FUNERAL DIRECTOR <u>Bernard Danzansky &amp; Sons</u>		25a. REC'D BY REGISTRAR <u>St. NW, Wash. DC</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		MAR 15 1967	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03814

## CERTIFICATE OF DEATH

03814

<b>1 PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joplin</u>		<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution or Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>WASHER</u> d. STREET ADDRESS <u>53 N. Moffett Ave</u>	
<b>3 NAME OF DECEASED</b> (Type or print) <u>Sarah Goldstein</u> e. SEX <u>F</u> f. COLOR OR RACE <u>W</u> g. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> h. DATE OF BIRTH <u>7-23-82</u> i. WIDOWED <input checked="" type="checkbox"/> j. DIVORCED <input type="checkbox"/> k. AGE (In years last birthday) <u>84</u> yrs.		l. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> m. IF UNDER 1 YEAR: Months <u>13</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Kansas City, Missouri</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>ISADORE RINGOLSKY</u> 14. MOTHER'S MAIDEN NAME <u>HELEN ROSENFELD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>490-32-9346</u> 17. INFORMANT <u>Admission Record</u> Address		<b>18 CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Chronic Bronchitis</u> DUE TO (c) <u>3 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	
<b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <u>Coronary Arteriosclerosis, Acute Hepatitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1</u> , 19 <u>66</u> to <u>March 13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 13</u> , 19 <u>67</u> , and that death occurred at <u>9 P.M.</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Blaine H. Felt</u> 22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. FELT</u>		22b. DATE SIGNED <u>March 13, 1967</u> 22d. ADDRESS <u>8641 Coleridge Rd. Delmar, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3-16-67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>MT. HOPE Cem.</u> 23d. LOCATION (City or Town) (County) (State) <u>Joplin Mo.</u>		24. FUNERAL DIRECTOR <u>Goldberg Funeral Home 4217-9th St. N.W.</u> 25a. REC'D BY REGISTRAR <u>15 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

**03815**

**03812**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY IN TB <u>43 days</u>		d. STREET ADDRESS <u>8308 Flower Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. &amp; Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Edward Gooden</u>		4. DATE OF DEATH Month <u>3</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-21-90</u>
9. AGE (in years lost birthday) <u>77</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Salesman</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer. U.S.A.</u>	
13. FATHER'S NAME <u>John Gooden</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Duff</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO <u>218-01-860</u>	
17. INFORMANT <u>Elizabeth Gooden</u> Address <u>8308 Flower Ave. Takoma Park, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Bacterial infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Pulmonary emphysema - chronic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease - old MI; BPH</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-14-67</u> , 19 <u>50</u> to <u>3-29-1967</u> , that (I) (we) last saw the deceased alive on <u>29 Mar</u> 1967, and that death occurred at <u>10 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Kenneth B. Cruze</u> M.D.		22b. DATE SIGNED <u>3/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Kenneth B. Cruze</u>		22d. ADDRESS <u>831 University Blvd. E., Silver Spring, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Mar 31, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>Thomas E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>APR 3 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



## CERTIFICATE OF DEATH

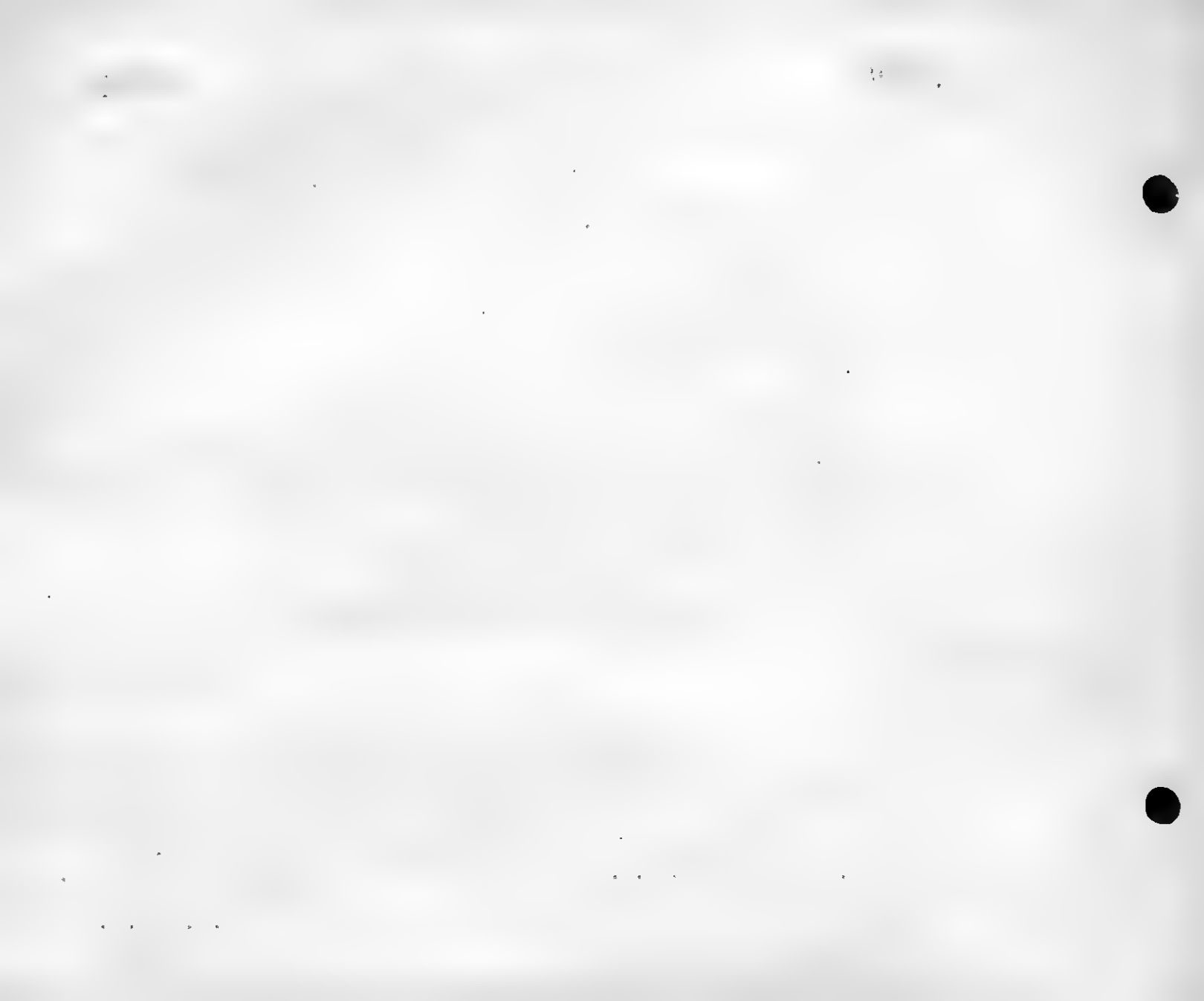
03816

03313

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>New York</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>15 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>		e. STREET ADDRESS <b>2287 Mott Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Beatrice (None) Greene</b>		4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>29 April 1914</b>
9. AGE (In years, just birthday) <b>52</b> yrs		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>67</b> Min	
10a. USUA. OCC. PAT ON (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph James</b>		14. MOTHER'S MAIDEN NAME <b>Ida Laden</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>062-30-8440</b>	
17. INFORMANT <b>The Medical Records</b>		18. ADDRESS <b>The Clinical Center, Bethesda, Maryland</b>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) <b>Atheromatous Vascular Disease</b> DUE TO (c) <b>Type III Hyperlipoproteinemia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>45 years</b> <b>52 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>20 Feb.</b> , 19 <b>67</b> , to <b>7 March</b> , 19 <b>67</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>7 March 1967</b> , and that death occurred at <b>10:00M</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>W. Virgil Brown, M.D.</b>		22b. DATE SIGNED <b>8 March 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. Virgil Brown, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>	23b. DATE THEREOF <b>3-10-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Beth David Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Elmont, L.I., N.Y.</b>
24. FUNERAL DIRECTOR <b>Bernard Danzansky and Sons</b>		25a. REC'D BY REGISTRAR <b>MAR 9 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





FOR STATE  
HEALTH DEPT.

03817

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03814

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>Do A</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>10266 Ruman Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Robin</u> First <u>Elaine</u> Middle <u>Greene</u> Last		4. DATE OF DEATH <u>March 16</u> 19 <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 25 1964</u>
9. AGE (In years last birthday) yrs <u>3 1/2</u>		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>16</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland - Mont.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Algie Greene</u>		14. MOTHER'S MAIDEN NAME <u>Patricia Bolt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mother - Same as above</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>pneumonia. Interstitial.</u> 525 X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>12 hr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.		22. DATE SIGNED <u>3/16/67</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-18-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cem. Vinton, Va.</u>	23d. LOCATION (City or Town) (County) (State) <u>Vinton, Virginia</u>
24. FUNERAL DIRECTOR <u>Lutz Funeral Home</u>		25. REC'D BY REGISTRAR <u>1001 Franklin Rd. Warrenton, Va.</u> DATE <u>MAR 21 1967</u>	
		25a. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



CERTIFICATE OF DEATH

03818

03815

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>ROCKVILLE</u>		c. LENGTH OF STAY IN 1b. <u>15 YRS.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>106 Upton Street</u>		d. STREET ADDRESS <u>106 Upton Street</u>	
3. NAME OF DECEASED (Type or print) <u>SARAH H. Griffith</u>		4. DATE OF DEATH <u>March 3 1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 14, 1881</u>
9. AGE (In years last birthday) <u>85</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>AARON B. HERSHBERGER</u>		14. MOTHER'S MAIDEN NAME <u>HESTER ANN WHIPP</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS. JOHN BACKUS</u>		Address <u>SAME AS ITEM #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MI</u> DUE TO (b) <u>arteriosclerotic cardiovascular renal disease</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>—</u> p.m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> , 19 <u>—</u> to <u>March 3, 1967</u> , that (I) (we) lost saw the deceased alive on <u>March 3, 1967</u> , and that death occurred at <u>5:00 P.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>W. A. Linthicum</u>		22b. DATE SIGNED <u>3/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. A. Linthicum, M.D.</u>		22d. ADDRESS <u>1105 Washington St. Rockville, Md.</u>	
23a. BURIAL CREMATON, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-6-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MONOCACY CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>BEALLSVILLE MONTG M.D.</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>		25a. REC'D BY REGISTRAR <u>MAR 10 1967</u>	
ADDRESS <u>BETHESDA MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03819

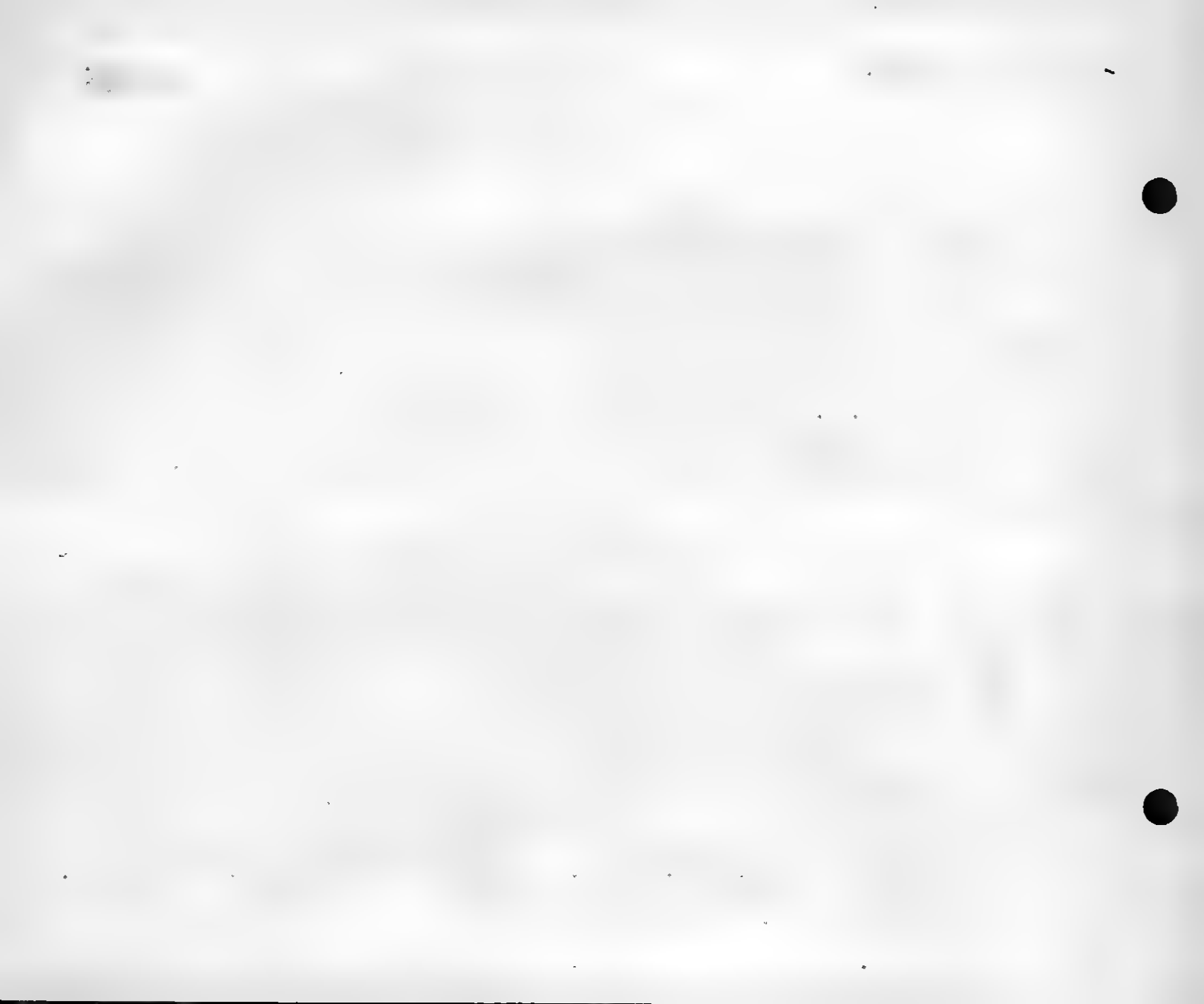
## CERTIFICATE OF DEATH

03316

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>North Dakota</b> b. COUNTY <b>Colgan</b>	
c. LENGTH OF STAY IN 1b <b>91 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colgan</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>		d. STREET ADDRESS <b>None</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Robert Wayne Haagenenson</b>		4 DATE OF DEATH Month Day Year <b>March 15 1967</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>20 August 1962</b>
9 AGE (In years last birthday) <b>4 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min <b>4 yrs</b>	
10a. U.S. JAL OCCUPATION (Give kind of work done during most of working life, except if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>North Dakota</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert I. C. Haagenenson</b>		14. MOTHER'S MAIDEN NAME <b>Sandra Dixon</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>None</b>	
17 INFORMANT <b>The Medical Records</b>		18 ADDRESS <b>The Clinical Center, Bethesda, Maryland</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Respiratory insufficiency</b> DUE TO (b) <b>Pneumonia undertermined etiology</b> DUE TO (c) <b>Acute lymphatic leukemia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>3 days</b> <b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>14 December, 1966</b> , to <b>15 March, 1967</b> , that (we) saw the deceased alive on <b>15 March 19 67</b> , and that death occurred at <b>6:30 M.</b> from causes on and the date stated above			
22a. SIGNATURE <b>Herbert E. Kann, Jr., M.D.</b>		22b. DATE SIGNED <b>16 March 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Herbert E. Kann, Jr., M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<b>Burial-transit 3-18-67</b>		<b>Colgan Cemetery</b>	<b>Colgan, North Dakota</b>
24 FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAR 22 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If only day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03820

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03817

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>4216 Garrett Park Rd.</b> <b>151</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>				d. STREET ADDRESS <b>Silver Spring</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Daisy</b> Middle <b>Loretta</b> Last <b>Hackley</b>				4 DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>19 67</b>			
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>10/12/95</b>	9 AGE (in years last birthday) <b>71</b> yrs	IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b>		IF UNDER 24 HRS Hours <b>67</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School Cafe.</b>		11. BIRTHPLACE (State or foreign country) <b>Loudoun Co., Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Abraham Greenwald</b>				14. MOTHER'S MAIDEN NAME <b>(Name) Mary Magdalene Mirley</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>212-24-6031A</b>		17. INFORMANT <b>Son,</b> Address <b>Howard Hackley 4216 Garrett Pk Rd. S.S., Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4201 Coronary Insufficiency, Acute.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiovascular Disease -</b> DUE TO (c) <b>Sudden</b> <b>Years -</b>							INTERVAL BETWEEN ONSET AND DEATH <b>30 days</b>
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John B. Ball</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>3/7/67</b>	
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/11/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Loudoun Hgts. Loudoun Va</b>	
24. FUNERAL DIRECTOR <b>Donald Eckley</b> ADDRESS <b>Harpers Ferry, W.Va.</b>				25a. REC'D BY REGISTRAR <b>MAR 13 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #2a,b,c & d Film #G387 4/6/67 pc

03821

CERTIFICATE OF DEATH

03818

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND/ N.Y.</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>9 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY/ New York City</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>LeMarquis Hotel E-31st</b> <b>BROOKE/GROVE FOUNDATION Street</b>			
3 NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>ELAM</b> Last <b>HACKMAN</b>				4 DATE OF DEATH Month <b>3</b> Day <b>15</b> Year <b>1967</b>			
5 SEX <b>FEMALE</b>		6 COLOR OR RACE <b>WHITE</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>7-1-97</b>	
9. AGE (In years last birthday) yrs <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO		17. INFORMANT <b>MEDICAL RECORDS DEPT.</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia 2 hypostatic</b> DUE TO (b) <b>Paralytic Illness</b> DUE TO (c) <b>Electrolyte imbalance</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							INTERVAL BETWEEN ONSET AND DEATH <b>2 hr</b> <b>2 hr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1st hemiplegia</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/15</b> 19 <b>67</b> to <b>3/15</b> 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>3/15</b> 19 <b>67</b> , and that death occurred at <b>1:35 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>[Signature]</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>3/15/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. H. LIGON, M. D.</b>				22d. ADDRESS <b>MEDICAL CENTER, SANDY SPRING, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>3/17/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince George Co., Md.</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



FOR STATE  
HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03822 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03319											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if inst. in on Res. before adm. on) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN lb <u>9 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1605 BRISBANE ST</u>						d. STREET ADDRESS <u>1605 BRISBANE ST</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>CALVIN Webster HAKE</u>						4. DATE OF DEATH Month Day Year <u>3 - 12 - 1967</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 11, 1882</u>		9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinetmaker</u>				11b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Lancaster, Penna.</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel W. Hake</u>						14. MOTHER'S MAIDEN NAME <u>Jane (Unknown)</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv.) <u>No</u>				16. SOC. A. SECURITY NO. <u>214-03-8875-A</u>		17. INFORMANT <u>Margaret Hake</u> Address <u>1605 Brisbane Street Silver Spring, Maryland</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.						22. DATE SIGNED <u>3/13/1967</u>					
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>						Address <u>1605 Brisbane Street Silver Spring, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 16, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hyattsville, Md.</u>					
24. FUNERAL DIRECTOR <u>John B. Thomas</u> Address <u>44 Georgia Avenue</u> <u>Warner E. Humphrey, Inc.</u> <u>Silver Spring, Md.</u>						25a. REC'D BY REGISTRAR <u>MAR 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



03823

## CERTIFICATE OF DEATH

03820

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Res dence before admision) a. STATE <b>South Carolina</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Columbia</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp'tal, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>2115 Huffman Drive</b>	
3. NAME OF DECEASED (Type or print) <b>James Robert HAMLETT</b>		4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1940</b>
9. AGE (In years last birthday) <b>27</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Greenville, Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Lloyd Hamlett</b>		14. MOTHER'S MAIDEN NAME <b>Janie Louise Kelly</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes give war or dates of service) <b>1959-1967</b>		16. SOCIAL SECURITY NO <b>260 58 6719</b>	
17. INFORMANT <b>Columbia</b>		Address <b>S. C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hemorrhagic bronchial pneumonia</b> 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute lymphoblastic leukemia</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 2, 1967</b> , to <b>March 2, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 2, 1967</b> , and that death occurred at <b>1035 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>J. B. Emery, Jr.</i>		22b. DATE SIGNED <b>March 3, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. B. Emery, Jr., M. D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-6-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Newnan Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Newnan, Georgia</b>
24. FUNERAL DIRECTOR <b>W. W. Chambers Co.</b> ADDRESS <b>1400 Chapin St., N.W., Washington, D.C.</b>		25a. REC'D BY REGISTRAR <b>MAR 6 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03824

## CERTIFICATE OF DEATH

03824

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN IB <b>15 hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>		d. STREET ADDRESS <b>4507 Highland Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>M.</b> Last <b>HAMMERLI</b>		4. DATE OF DEATH Month <b>Mar.</b> Day <b>19</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 14, 1875</b>
9. AGE (In years last birthday) <b>91</b> yrs		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Mins <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Switzerland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Switzerland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Switzerland</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-30-3920</b>	
17. INFORMANT <b>Son</b>		Address <b>Same as Item 2.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Thrombosis Left Carotid Artery</b> 332X DUE TO (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>1042</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>24 HRS</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>18 MAR</b> , 19 <b>67</b> , to <b>19 MAR</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>18 MAR</b> 19 <b>67</b> , and that death occurred on <b>2 A.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Ronald W. Barr</i>		22b. DATE SIGNED <b>3-19-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>RONALD W. BARR, MD.</b>		22d. ADDRESS <b>10401 OLD GEORGETOWN RD. BETHESDA, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-22-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Rockville, Maryland</b>
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. RECEIVED BY REGISTRAR <b>MAR 28 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





03825

CERTIFICATE OF DEATH

03822

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8712 Rayburn Road</u>		d. STREET ADDRESS <u>8712 Rayburn Road</u>	
3 NAME OF DECEASED (Type or print) First <u>Chai</u> Middle <u>Kon</u> Last <u>Han</u>		4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 7, 1887</u> 79 YRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) <u>Korea</u>
13. FATHER'S NAME <u>Chong Eung Lee</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. -----	17. INFORMANT <u>Dr. Pum Suk Han - son - same item #2</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular C. Vascular</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Generalized Arteriosclerosis</u> (c) <u>Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>High blood pressure and diabetes mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 8</u> , 19 <u>67</u> , to <u>March 1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb 22</u> , 19 <u>67</u> , and that death occurred at <u>11:45</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>George H. Mitchell</u>		22b. DATE SIGNED <u>March 1 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>George H. Mitchell</u>		22d. ADDRESS <u>11125 Rockville Pike, Rockville, Md.</u>	
23a. BURIAL, CREMATON, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Md.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 3 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03826

CERTIFICATE OF DEATH

03823

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write BUREAU and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN TB <b>4977 Battery Lane</b>		2. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>4977 Battery Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Jack</b> First Middle Last <b>Haney</b>		4. DATE OF DEATH Month Day Year <b>3-28-1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-24-1912</b>
9. AGE (In years last birthday) <b>54</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Post Office</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Roy Wilbur Haney</b>		14. MOTHER'S MAIDEN NAME <b>Marie Simmons</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO <b>280-05-5969</b>	
17. INFORMANT <b>J. W. Peregoy, 7801 Fulbright Ct.</b>		Address <b>Bethesda, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO (b) <b>Carcinoma of left colon</b> DUE TO (c) <b>6 mos</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1953</b> to <b>Mar 28, 1967</b> , that (I) (we) last saw the deceased alive on <b>Mar 27, 1967</b> , and that death occurred at <b>12:15 PM</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>Thomas F. McMahon</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Thomas F. McMahon M.D.</b>		22d. ADDRESS <b>3000 Penn. Ave. Wash. D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>4-1-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland, Md.</b>
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>		25a. REC'D BY REGISTRAR <b>APR 3 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03827

## CERTIFICATE OF DEATH

03824

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie, Maryland</u> <u>20175</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>12824 Holiday Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Christine</u> Middle <u>Louise</u> Last <u>Hanlon</u>				4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>1967</u>			
5 SEX <u>Female</u>		6 CO. OR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>19</u> <u>MARCH</u> , <u>1967</u>	
9 AGE (In years last birthday) yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b KIND OF BUSINESS OR INDUSTRY		9 AGE (In years last birthday) yrs	
11. BIRTHPLACE (County & State, or foreign country) <u>Silver Spring, Md.</u>				12 CITIZEN OF WHAT COUNTRY?			
13 FATHER'S NAME <u>Gerald V. Hanlon</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Mary Maloney</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16 SOCIAL SECURITY NO -----		17 INFORMANT <u>Gerald V. Hanlon - father - same it as 142</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO (b) <u>Respiratory distress syndrome, prematurity</u> DUE TO (c) <u>ecchymosis of retinopathy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 19, 1967</u> , to <u>Mar 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar 21, 1967</u> , and that death occurred at <u>11:15</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Morris Fintel</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-21-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MORRIS FINTEL MD</u>				22d. ADDRESS <u>704 German Ave Laurel Md.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial - same</u>		23b. DATE THEREOF <u>3/23/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u>		23d. LOCATION (City or Town) (County) (State) <u>Chicago, Ill.</u>	
24 FUNERAL DIRECTOR <u>Tyson Heeler Funeral Home</u>				25a. RECD BY REGISTRAR <u>Mar 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03828

## CERTIFICATE OF DEATH

03825

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Ellis</u> ✓ <u>Waxahachie, Texas</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN TB <u>9 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sylvan Manor Nursing Home, Rockawayville</u>		d. STREET ADDRESS <u>200 Overhill Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>Zephna J. HARDING</u>		4. DATE OF DEATH <u>MAR 3 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Can.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>18 Feb 1869</u>
9. AGE (In years last birthday) <u>98</u> yrs		IF UNDER 1 YEAR: Months <u>3</u> Days <u>3</u> Hours <u>19</u> Min <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (Country & State, or foreign country) <u>Ellis Co. Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Aaron Trippet</u>		14. MOTHER'S MAIDEN NAME <u>Martha Cock</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>yes</u>	
17. INFORMANT <u>Beatrice Armstrong</u>		Address <u>9212 Columbia Blvd. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>last</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> to <u>Mar 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb 28, 1967</u> , and that death occurred at <u>1:55 P.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>Robert T. Thibadeau</u>		22b. DATE SIGNED <u>Mar 3-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU</u>		22d. ADDRESS <u>11,000 OLD GEORGETOWN ROAD ROCKVILLE, MD 20852</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7 March 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Waxahachie City Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Waxahachie, Ellis, Texas</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas Warner E. Humphrey, Inc.</u>		25a. REG'D BY REGISTRAR <u>8434 Georgia Ave Silver Spring, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>		DATE <u>MAR 8 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7 61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
03829						03826							
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)							
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY				
Montgomery			Cedar Grove			Maryland			Montgomery				
c. LENGTH OF STAY IN 1b			d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS				
5 years						Rt. #1 Germantown,			Box 112				
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH							
First Middle Last						Month Day Year							
Mary Agnes Hargraves						March 22 1967							
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days			
F		W				Aug. 21, 1881		85 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Clerk				Magazine Publishing				Washington, D. C.		USA			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME							
John Blackston Riley						Margaret Agnes Williams							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO.						17. INFORMANT Address	
No												Marguerite Appleby Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												2 weeks	
1. Terminal Bronchopneumonia													
DUE TO													
2. Arteriosclerotic Cardio-vascular-renal Disease												15 years?	
DUE TO													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)													
No accident.													
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)			
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						(State)			
21. I certify that (I) (the undersigned) attended the deceased from August 1, 1965, to March 22, 1967, that (I) (we) last saw the deceased alive on March 22, 1967, and that death occurred at 12 noon, from the causes and on the date stated above.													
22a. SIGNATURE												22b. DATE SIGNED	
M. McKendree Boyer, M. D.												March 24, 1967	
22c. PHYSICIAN'S NAME (Type)													
23a. BURIAL, CREMATION REMOVAL (Specify)												23b. DATE THEREOF	
Burial												3-25-67	
23c. NAME OF CEMETERY OR CREMATORY												23d. LOCATION (City, town or county)	
Glenwood Cemetery												Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE												25a. REC'D BY REGISTRAR	
Francis H. Barber												MAR 29 1967	
Laytonsville, Md.												25b. REGISTRAR'S SIGNATURE	
												Charles Judge	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03830

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03827

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Takoma Park</b>				c LENGTH OF STAY IN 1b <b>8 days</b>			
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Takoma Park</b>				d STREET ADDRESS <b>7111 Popular Avenue</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>Myra</b> Middle <b>May</b> Last <b>Harman</b>				4 DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>19 67</b>			
5 SEX <b>Female</b>		6 COLOR OR RACE <b>White</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>7-11-90</b>	
9 AGE (in years last birthday) yrs <b>76</b>		10 UNDER 24 HRS Months <b>5</b> Days <b>19</b> Hours <b>67</b>		11 BIRTHPLACE (State or foreign country) <b>Florida</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b KIND OF BUSINESS OR INDUSTRY			
13 FATHER'S NAME <b>Charles Hulst</b>				14 MOTHER'S MAIDEN NAME <b>xx White</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16 SOCIAL SECURITY NO		17 INFORMANT <b>Hospital Records</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Coronary occlusion</b> DUE TO (c) <b>Cardio vascular disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks ?</b> <b>2 weeks</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Infarction of left cerebral hemisphere due to occlusion of left middle cerebral artery</b>							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Fell in hospital striking head on oxygen tank</b>			
20c TIME OF INJURY Month, Day, Year Hour o m <b>to 4:30 AM 3 3 19 67</b>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Hospital</b>	
20f (City or town) (County) (State) <b>Takoma Park Montgomery Md</b>							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John G. Ball</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JOHN G. BALL</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>3/7/67</b>			
				Address (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>March 8, 1967</b>		23c NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Colmar Manor, Prince Georges Co. Md.</b>	
24 FUNERAL DIRECTOR <b>Arthur Walters Washington D.C.</b>				25a DIED BY REGISTRAR <b>MAR 8 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Form 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03831

CERTIFICATE OF DEATH

03828

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>4 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HONY CROSS HOSPITAL</b>		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> d. STREET ADDRESS <b>8519 Glenview Ave #303</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>EMILY Ann NASSETT</b>		4 DATE OF DEATH Month Day Year <b>March 23 1967</b>	
5 SEX <b>F</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>6/18/13</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. K. NO. OF BUSINESS OR INDUSTRY <b>Own home</b>	9. AGE (In years last birthday) yrs <b>53</b>
11 BIRTHPLACE (County & State, or foreign country) <b>Dunkirk, New York</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Charles E. Smoczynski</b>		14. MOTHER'S MAIDEN NAME <b>Julia Spekeczynski</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>126-28-9816</b>	
17. INFORMANT <b>Francis Hassett</b>		Address <b>8519 Glenview Avenue Takoma Park, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Central nervous system Metastases</b> <b>1538</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Adenocarcinoma of Colon</b> stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b> <b>2 1/2 yrs</b>
19. WAS A Topsy PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>A</b>	20f. (City or town) (County) (State) <b>Dunkirk, New York</b>
21. I certify that (I) (this hospital) attended the deceased from <b>August 5, 1966</b> , to <b>3/23, 1967</b> , that (I) (we) last saw the deceased alive on <b>3/23 1967</b> , and that death occurred at <b>7:34 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>G. Lennard Gold</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>3/23/67</b>
22c. PHYSICIAN'S NAME (Type) <b>G. Lennard Gold, M.D.</b>		22d. ADDRESS <b>8641 Colesville Rd., Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Trans-burial</b>	23b. DATE THEREOF <b>Mar 27, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Dunkirk, New York</b>
24. FUNERAL DIRECTOR <b>John B. Thomas</b> <b>Warner E. Humphrey, Inc.</b>		ADDRESS <b>8434 Georgia Avenue</b>	25a. REC'D BY REGISTRAR <b>MAR 27 1967</b>
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

03832

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #G397 3/30/67

# CERTIFICATE OF DEATH

03829

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>D.C.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHEATON</b>			c. LENGTH OF STAY IN 1b <b>36 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>UNIVERSITY NURSING HOME</b>				d. STREET ADDRESS <b>1807-9th ST. N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>EDWARD</b> Last <b>HAWKINS</b>				4. DATE OF DEATH Month <b>3</b> Day <b>22</b> Year <b>1967</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1894</b> <b>4-3-1894</b>	
9. AGE (In years last birthday) <b>73 yrs</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOTEL WORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>CHARLES CO. MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>JAMES ROBERT HAWKINS</b>		14. MOTHER'S MAIDEN NAME <b>EMMA BARMAN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Unusually Fast Deposition</b> DUE TO <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Unusually Fast Deposition</b> DUE TO <b>Unusually Fast Deposition</b> (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe Rheumatoid Arthritis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Mar 12</b> , 19 <b>67</b> , to <b>Mar 22</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Mar 22</b> , 19 <b>67</b> , and that death occurred at <b>10:30 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Russell C. Bufalino</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Mar 23 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Russell C. Bufalino</b>				22d. ADDRESS <b>1729 University Blvd W.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/27/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Ceme.</b>		23d. LOCATION (City or Town) (County) (State) <b>Maryland</b>	
24. FUNERAL DIRECTOR <b>Stewart Funeral Home-4001 Benning Rd.</b>				25a. REC'D BY REGISTRAR <b>APR 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner

MONTGOMERY MARYLAND											
1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY IN 1b <b>3 xdxhr</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>						d. STREET ADDRESS <b>9607 Garwood Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Carl Leonard Hayden</b>						4 DATE OF DEATH Month <b>3</b> Day <b>27</b> Year <b>1967</b>					
5 SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>6/6/07</b>		9 AGE (In years last birthday) <b>59</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired policeman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>D.C. police Dept</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Wayside, Md</b>				12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lynn Hayden</b>						14. MOTHER'S MAIDEN NAME <b>Mary Wise</b>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO None</b>				16 SOCIAL SECURITY NO <b>216-46-9386</b>		17 INFORMANT <b>Wife, Katherine Hayden</b> Address <b>9607 Garwood St. S. S., Md.</b>					
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>None</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>None</b> DUE TO (c) <b>None</b>										INTERVA. BETWEEN ONSET AND DEATH <b>None</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>None</b>				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>							
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>None</b>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f (City or town) (County) (State)		19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21 I certify that (I) (this hospital) attended the deceased from <b>January 1966</b> to <b>March 27, 1967</b> , that (I) (we) last saw the deceased alive on <b>February 2, 1967</b> , and that death occurred at <b>4:50 P.M.</b> from causes and on the date stated above.											
22a SIGNATURE <b>James Loftus, M.D.</b>						22b ADDRESS <b>5451 Conn. Ave., N.W., Washington, D.C.</b>		22c DATE SIGNED <b>March 27, 1967</b>		22d MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b DATE THEREOF <b>Mar. 30, 1967</b>		23c NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>				23d LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>	
24 FUNERAL DIRECTOR <b>John B. Thomas</b>						25a REC'D BY REGISTRAR <b>WAR 31 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
26 ADDRESS <b>Warner E. Humphrey, Inc. Silver Spring, Md.</b>											



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03834

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03831

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Prince Williams</b> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb <b>2 Days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Triangle</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>			d. STREET ADDRESS <b>PO Box 151</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>Lee</b> Last <b>Hedges</b>			4 DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>19 67</b>		
5 SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 Dec 44</b>	9 AGE (In years last birthday) <b>22</b> yrs	10 UNDER 1 YEAR IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Navy</b>		11 BIRTHPLACE (State or foreign country) <b>Washington DC</b>	
13 FATHER'S NAME <b>Paul Lee Hedges</b>			14. MOTHER'S MAIDEN NAME <b>Rosemarie Micheline Barriette</b>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>223 60 9378</b>		17. INFORMANT <b>Paul L. Hedges PO Box 151 Triangle, Va.</b>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Laceration and contusion of brain</b> DUE TO (b) <b>Skull fracture</b> DUE TO (c) <b>Trauma from automobile accident</b>					INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>10:30</b> p.m. <b>Mar. 24 19 67</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Street</b>	
		20f. (City or town) <b>Woodbridge</b>		(County) <b>William</b> (State) <b>Va.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John G. Ball</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>27 Mar 67</b>	
EXAMINER'S NAME (Type) <b>John G. Ball, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		Address (Street, city, town or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial in room</b>		23b. DATE THEREOF <b>3/27/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dumfries Cemetary</b>	
				23d. LOCATION (City or Town) (County) (State) <b>Dumfries, Prince Wm. Va.</b>	
24. FUNERAL DIRECTOR <b>W. W. Chambers Co., 1400 Chapin St. NW, Wash. D.C.</b>		25a. REC'D BY REGISTRAR <b>MAR 29 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

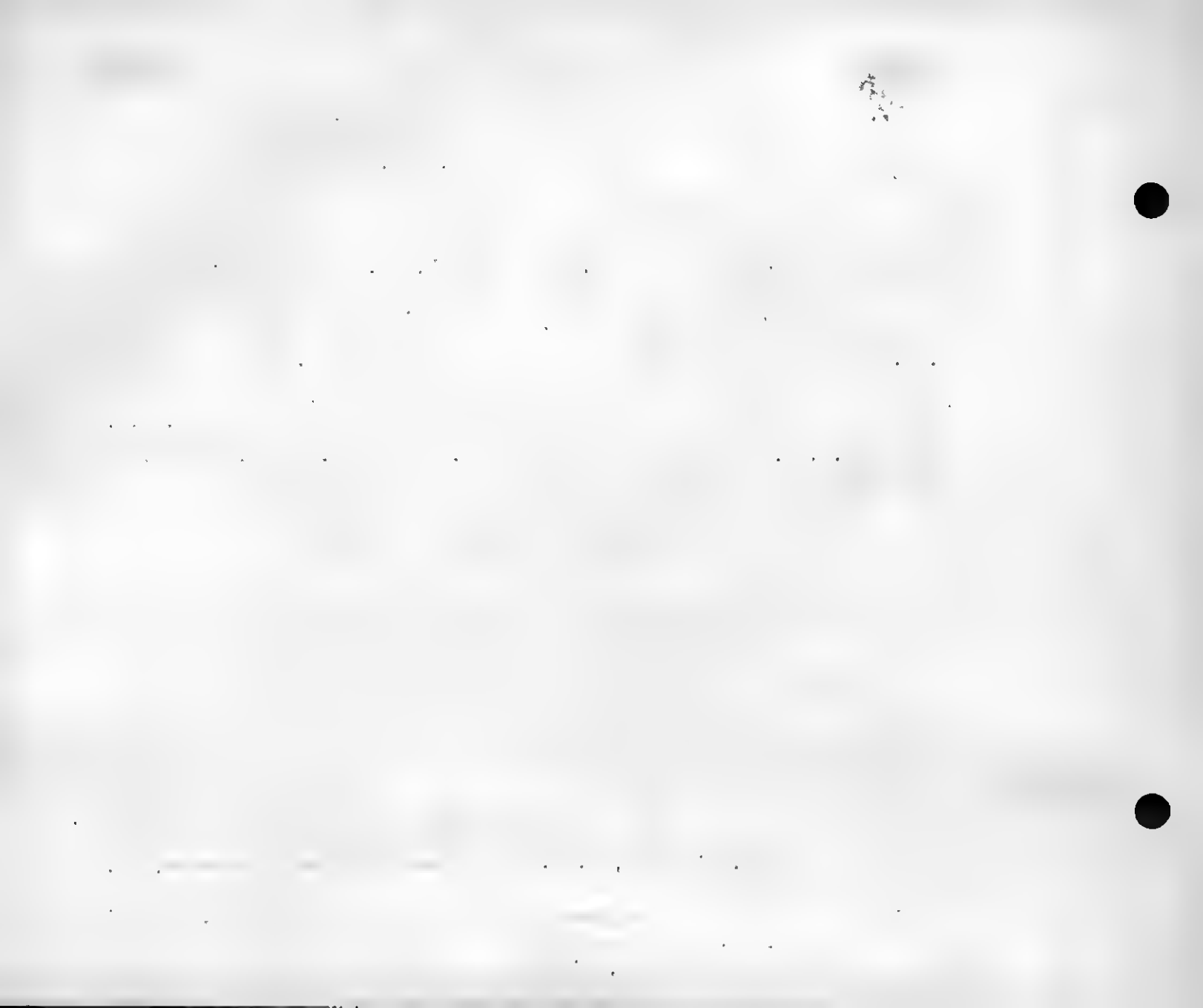
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03835

CERTIFICATE OF DEATH

03833

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>8 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gainesville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				d. STREET ADDRESS <b>RFD #1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>John F. HENRY, SR.</b>				4. DATE OF DEATH Month Day Year <b>March 22 19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 23, 1899</b>		9. AGE (In years last birthday) yrs <b>67</b>		IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Marine Corps</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Manhattanville, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Joseph Henry</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Nevins</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W.W. 1, 2, Korean</b>		16. SOCIAL SECURITY NO <b>087 09 4765</b>		17. INFORMANT <b>Mrs. Kathryn M. Henry, RFD #1, Gainesville</b>		Address <b>Virginia</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the lung</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>40</del> (this hospital) attended the deceased from <b>March 14, 1967</b> to <b>March 22, 1967</b> that <del>40</del> (we) last saw the deceased alive on <b>March 22, 1967</b> , and that death occurred at <b>355 PM</b> , from causes and on the date stated above							
22a. SIGNATURE <i>Peter T. Kirchner</i> M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>March 23, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Peter T. Kirchner, M. D.</b>				22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/27/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>Everly-Wheatley Funeral Home</b> <b>1500 West Braddock, Alexandria, Virginia</b>				25a. REC'D BY REGISTRAR <b>MAR 29 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03836

CERTIFICATE OF DEATH

03834

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>	
c. LENGTH OF STAY IN TB <u>24da</u>		d. STREET ADDRESS <u>7108 MAPLE AVE.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN. + HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANCISCO (NONE) HERNANDEZ</u>		4. DATE OF DEATH <u>March 9 - 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6/15/07</u>
9. AGE (in years) <u>59</u> yrs		10. IF UNDER 1 YEAR: Months <u>9</u> Days <u>1</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BAR TENDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CUBA</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>CUBA</u>		12. CITIZEN OF WHAT COUNTRY? <u>CUBA</u>	
13. FATHER'S NAME <u>FRANCISCO HERNANDEZ</u>		14. MOTHER'S MAIDEN NAME <u>CARMAN MONTILLA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Hospital RECORDS</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tumor right hypopharynx and right neck area</u> DUE TO (b) <u>neck area</u> DUE TO (c) <u>neck area</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Since Oct 67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary carcinoma</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>he</u> (this hospital) attended the deceased from <u>Feb 14</u> , 1967, to <u>March 9</u> , 1967, that <u>he</u> (we) last saw the deceased alive on <u>March 9</u> , 1967, and that death occurred at <u>7:10</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Aaron H. Traum</u>		22b. DATE SIGNED <u>March 10 '67</u>	
22c. PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>		22d. ADDRESS <u>5237 Georgia Ave N.W. Spring Mount, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>March 13 - 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>	23d. LOCATION (City or town) (County) (State) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR <u>J. W. Williams</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
25c. ADDRESS <u>254 Cottage St. W. Washington, D.C. 20012</u>		DATE <u>MAR 13 1967</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 11 and 12 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CASE DISCUSSED WITH CO. H.E. and C. REID.

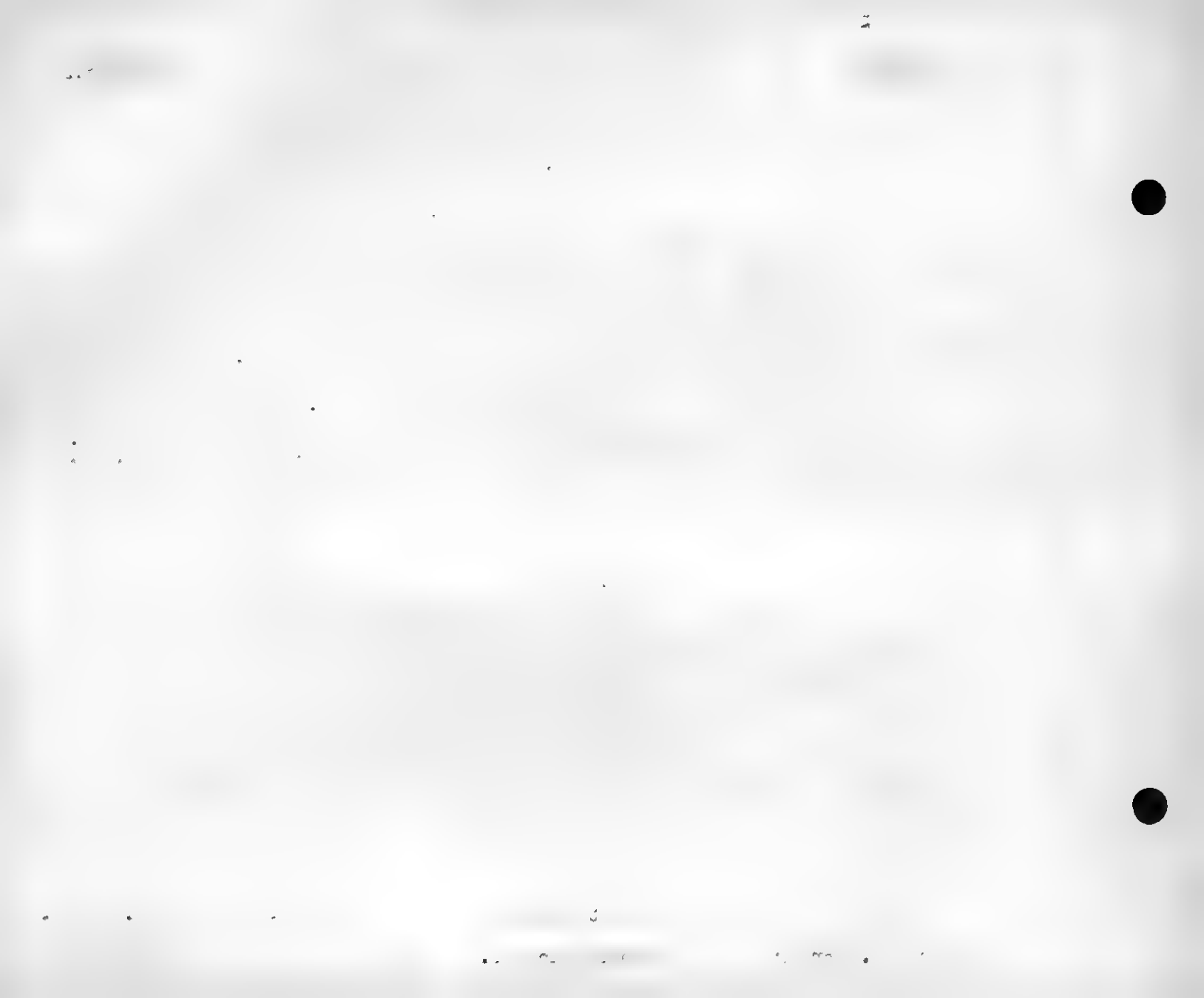
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03837

CERTIFICATE OF DEATH

03835

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN b. <b>1 Year</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>✓</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New York City</b> d. STREET ADDRESS <b>YVCA--</b> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Haddie Grace Hernandez</b>		4. DATE OF DEATH Month <b>3</b> Day <b>3</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/15/01</b> 9. AGE (In years last birthday) <b>66</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Registered Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Psychiatric Nurse</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Philadelphia, Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Hernandez</b>		14. MOTHER'S MAIDEN NAME <b>Haddie K. Thorman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>042 26 0149</b>	
17. INFORMANT <b>Dorothy Fisk, Sister, 15305 Good Hope Rd. Silver Spring, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO (b) <b>ISCHEMIC HEART DISEASE</b> DUE TO (c) <b>ARTERIO-SCLEROTIC C.V. DISEASE</b> INTERVAL BETWEEN ONSET AND DEATH: <b>SODDEN</b> <b>YRS.</b> <b>YRS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>DIABETES MELLITUS - HYPERTENSION - ANGINA PECTORIS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>OCTOBER 1966</b> to <b>MARCH 3, 1967</b> , that (1) (we) last saw the deceased alive on <b>FEB 27 1967</b> , and that death occurred at <b>5:30 P.M.</b> from causes and on the date stated above			
22a. SIGNATURE <b>Donald L. Lewis</b>		22b. DATE SIGNED <b>MARCH 3, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Donald L. Lewis</b>		22d. ADDRESS <b>Medical Center, Olney, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>March 6 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Laytonsville</b>	23d. LOCATION (City or town) (County) (State) <b>Laytonsville Mont. Md.</b>
24. FUNERAL DIRECTOR <b>Francis H. Barber</b>		25a. REC'D BY REGISTRAR <b>MAR 8 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1-66

03838

CERTIFICATE OF DEATH

03838

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda Silver Spring Nursing Home</u>		d. STREET ADDRESS <u>3113-LEE STREET</u>	
3 NAME OF DECEASED (Type or print) <u>Mary Elizabeth Hiley</u>		4. DATE OF DEATH <u>3 - 30 - 1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-71</u>
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Charlie Blalock</u>		14 MOTHER'S MAIDEN NAME <u>Mattie Ferguson</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>---</u>	
17. INFORMANT <u>Walter M. Hiley - 13111 Evanston St.</u>		Address <u>Rockville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200 CARDIAC FAILURE</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 YRS</u> <u>5 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>OCT 15</u> , 19 <u>66</u> , to <u>MARCH 30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>MARCH 29</u> , 19 <u>67</u> , and that death occurred at <u>12 A.M.</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Thomas F. C'CONNOR</u>		22b. DATE SIGNED <u>3/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. C'CONNOR</u>		22d. ADDRESS <u>8218 WISCONSIN AVE, BETHESDA, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-3-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>APR 3 1967</u>	
ADDRESS <u>5150 Wisconsin Ave. N.W., Wash. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03839

CERTIFICATE OF DEATH

03837

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>				d. STREET ADDRESS <u>16902 Oak Hill Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Ernest</u> Last <u>Hill</u>				4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>11-15-08</u>		9. AGE (In years last birthday) <u>58</u> yrs	IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Hill</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Mitchel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C.V.A. - (coronary artery insufficiency)</u> <u>731X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <u>Diabetes mellitus - Pulmonary tuberculosis (inactive)</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (H) (this hospital) attended the deceased from <u>Feb 16</u> , 1967, to <u>March 4</u> , 1967, that (H) (we) last saw the deceased alive on <u>March 4</u> , 1967, and that death occurred at <u>8:15 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Allen H. Trautman</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>March 4, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Allen H. Trautman</u>				22d. ADDRESS <u>8137 Georgia Ave - Silver Spring, Maryland, 20910</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/8/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Sandy Springs, Md</u>	
24. FUNERAL DIRECTOR <u>Robert C. Snowden Rockville, Md</u>				25a. REC'D BY REGISTRAR <u>MAR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div style="display: flex; justify-content: space-between;"> <div> <p>1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>3 months, 3 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Fairland Nursing Home</b></p> </div> <div> <p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>10135 Crestwood Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> </div> </div>											
3. NAME OF DECEASED (Type or print) <b>John</b>			4. DATE OF DEATH Month <b>3</b> - Day <b>2</b> - Year <b>1967</b>								
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-17-90</b>	9. AGE (In years last birthday) <b>77</b> yrs.	10. IF UNDER 1 YEAR Months <b>7</b> Days <b>2</b> Hours <b>15</b> Min.						
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Carpentry</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Austria</b>							
13. FATHER'S NAME <b>- - -</b>			14. MOTHER'S MAIDEN NAME <b>- - -</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>- - -</b>		16. SOCIAL SECURITY NO. <b>092-09-5290</b>		17. INFORMANT <b>Walter Hnatysh</b> Address <b>Kensington, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>351X</b> DUE TO (b) <b>Cerebral arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>4K5</b>					INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)						
21. I certify that (I) (this hospital) attended the deceased from <b>12/1</b> , 19 <b>62</b> , to <b>3/2</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3/1</b> , 19 <b>67</b> , and that death occurred at <b>4:30</b> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <b>Raymond T. Benack MD</b>			22b. DATE SIGNED <b>3/2/67</b>								
22c. PHYSICIAN'S NAME (Type) <b>Raymond T. Benack MD</b>			22d. ADDRESS <b>4115 Colie Drive, Wheaton, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>3-4-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	23d. LOCATION (City, town or county) (State) <b>Suitland, Md.</b>								
24. FUNERAL DIRECTOR <b>JOSEPH CAWLEY</b>			25. REGISTRAR'S SIGNATURE <b>Charles Judge</b>								

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03841

CERTIFICATE OF DEATH

03839

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jakoma Park City</b>		c. LENGTH OF STAY IN IB <b>Ordg.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>		d. STREET ADDRESS <b>11 Leighton Place, S.S. Md 20901</b>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>CLYDE</b> Last <b>HOGAN</b>		4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/26/15</b>
9. AGE (In years last birthday) <b>41</b> yrs		IF UNDER 1 YEAR Months <b>2</b> Days <b>19</b> Hours <b>67</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Prin Pol / D.C. Public Serv</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CLYDE HOGAN</b>		14. MOTHER'S MAIDEN NAME <b>HELEN HUSSEY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>579-20-9992</b>	
17. INFORMANT <b>Mrs. Helen Hogan</b> Address <b>11 Leighton Place Silver Spring, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRO-VASCULAR ACCIDENT (RECURRENT)</b> DUE TO (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO (c) <b>RENAL-VASCULAR DISEASE (suspected)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>over 2 weeks</b> <b>over 2 years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>February 10, 1967</b> to <b>March 2, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 2, 1967</b> , and that death occurred at <b>1150P M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>Hugo G. Graziani</b> M.D.		22b. DATE SIGNED <b>March 3, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>HUGO G. GRAZIANI, M.D.</b>		22d. ADDRESS <b>10101 GEORGIA AVE, S.S., MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>March 4, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Crematory</b>	23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co., Md.</b>
24. FUNERAL DIRECTOR <b>C. Glen Carter</b> ADDRESS <b>8434 Georgia Avenue</b>		25a. REC'D BY REGISTRAR <b>Mar 8 1967</b>	
<b>Warner E. Pumphrey, Inc. Silver Spring, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the body from the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03842

CERTIFICATE OF DEATH

03840

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE, WEST</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SAN. &amp; HOSP.</b>		d. STREET ADDRESS <b>2103 GUFORD Rd.</b>	
3 NAME OF DECEASED (Type or print) <b>VIRGINIA ELIZABETH HOLLAND</b>		4 DATE OF DEATH Month <b>MARCH</b> Day <b>4</b> Year <b>1967</b>	
5 SEX <b>FE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>9/17/1927</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <b>39</b>
11. BIRTHPLACE (County & State, or foreign country) <b>DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Lovel</b>		14. MOTHER'S MAIDEN NAME <b>SARAH QUARMAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Terminal Pneumonia</b> DUE TO (b) <b>C.V.A.</b> DUE TO (c) <b>Hypertensive A.S.H.D.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>5 years</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1963</b> , 19 to <b>3/4</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3/4</b> , 19 <b>67</b> , and that death occurred at <b>6:50</b> P.M., from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED <b>3-4-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lee F. Funchal</b>		22d. ADDRESS <b>7105 RIGGS RD, HYATTSVILLE MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3-8-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GLENWOOD CEM.</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>
24. FUNERAL DIRECTOR <b>Lee Funchal Home 3014 11th St. N.E. Wash. D.C.</b>		25a. REC'D BY REGISTRAR <b>MAR 10 1967</b>	
		25b. REGISTRAR'S SIGNATURE 	



1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03843

CERTIFICATE OF DEATH

03841

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>		c. LENGTH OF STAY IN 1b <u>1 month 30 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sylvan Manor Health Care Center</u>		d. STREET ADDRESS <u>13320 Dauphine St.</u>	
3. NAME OF DECEASED (Type or print) <u>BERTHA KATHERINE HORN</u>		4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/4/1899</u>
9. AGE (In years lost birthday) <u>67</u> YRS.		10. F UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>GEORGE WHITE</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE RAAB</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>YES W.W.I</u>		16. SOC. A. SEC. NO. <u>213-14-8148</u>	
17. INFORMANT <u>MRS. MARGARET K. MURPHY</u>		18. ADDRESS <u>13320 DAUPHINE ST. WHEATON, MD. 20906</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ectopic gestation - Sectio int.</u> DUE TO (b) <u>Carcinoma of cecum</u> DUE TO (c) <u>Primary Ca - Rectal ?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 14, 1967</u> to <u>March 15, 1967</u> that (I) (we) last saw the deceased alive on <u>Mar 14, 1967</u> , and that death occurred at <u>10 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert T. Thibadeau</u>		22b. DATE SIGNED <u>3/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU, MD</u>		22d. ADDRESS <u>ROCKVILLE, MD 20852</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3/20/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MD.</u>
24. FUNERAL DIRECTOR <u>Carlton Funeral Home, Catonsville, Md.</u>		25a. REC'D BY REGISTRAR <u>WEAR 20 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03844

CERTIFICATE OF DEATH

03842

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <b>West Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>78 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Francis David Housden</b>		4 DATE OF DEATH Month Day Year <b>March 17 1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>16 July 1951</b>
9 AGE (In years last birthday) yrs <b>15</b>		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Rufus M. Housden</b>		14. MOTHER'S MAIDEN NAME <b>Elsie P. Hite</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>None</b>	
17 INFORMANT <b>The Medical Records, The Clinical Center, Bethesda, Maryland 20014</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory Insufficiency</b> DUE TO (b) <b>Bronchiectasis</b> DUE TO (c) <b>Cystic Fibrosis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>Greater than 1 year</b> <b>Since birth</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>29 December, 1966</b> , to <b>17 March, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>17 March 1967</b> , and that death occurred at <b>12:02 AM</b> , and causes on the date stated above			
22a. SIGNATURE <b>Georges Peter</b>		22b. DATE SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>17 March 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Georges Peter, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>3-20-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Edge Hill</b>	23d. LOCATION (City or Town) (County) (State) <b>Charlottesville W. Va.</b>
24. FUNERAL DIRECTOR <b>Fitzsim 389 R.I. on NW Wash. &amp; D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 22 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





03845

CERTIFICATE OF DEATH

03843

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belted</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Steuers Spring</u>	
c. LENGTH OF STAY IN 1b <u>9 days</u>		d. STREET ADDRESS <u>4508 Bennett Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Synn</u> First <u>Howard</u> Middle <u>Howard</u> Last <u>Howard</u>		4 DATE OF DEATH <u>March 22</u> 19 <u>67</u> Month <u>March</u> Day <u>22</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/7/1895</u> 72 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ELEVATOR OPER.</u>	11. BIRTHPLACE (County & State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Robert Howard</u>	
14. MOTHER'S MAIDEN NAME <u>Martha W. Hutton</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO <u>577-14-857</u>		17. INFORMANT <u>Steuers Margaret McCormick</u> Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pericarditis and myocarditis, viral</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____			INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>March 13, 1967</u> , to <u>March 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 22, 1967</u> , and that death occurred at <u>150 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Stewart Clapp</u>		22b. DATE SIGNED <u>March 22 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp M.D.</u>		22d. ADDRESS <u>4740 Chevy Chase Dr. Chevy Chase Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3/25/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	23d. LOCATION (City or Town) <u>TR Geo Co. MD.</u> (County) _____ (State) _____
24. FUNERAL DIRECTOR <u>W.W. Chambers</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>MAR 28 1967</u>	
25b. REGISTRAR'S SIGNATURE _____		25c. ADDRESS <u>1400 CHAPIN ST N.W. D.C.</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

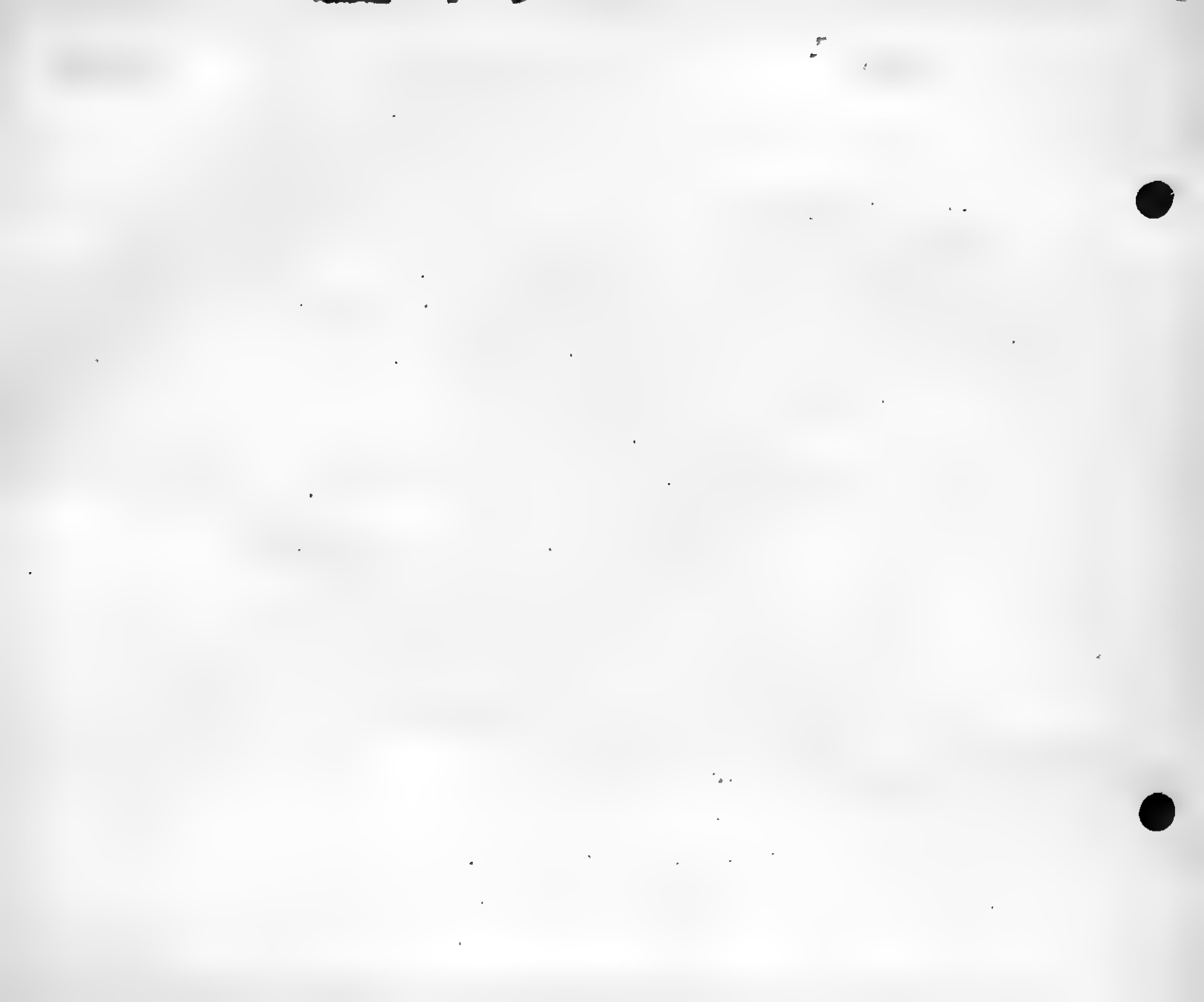
03846

CERTIFICATE OF DEATH

03844

Item #2d File #3300-3720/67-60

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland			b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 7 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital								
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH Month Day Year		
5. SEX male			6. COLOR OR RACE white			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH Dec. 12. 1883			9. AGE (In years last birthday) 83 yrs.			10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
11. BIRTHPLACE (County & State, or foreign country) Kansas			12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME John F. Howard			14. MOTHER'S MAIDEN NAME Martha Regan					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 519-11-190			17. INFORMANT Son - Paul C. Howard		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 350K DUE TO (b) Cerebral Venous Occlusion DUE TO (c) Bronchopneumonia, Cerebral hemorrhage PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 1958 to March 5, 1967, that (I) (we) last saw the deceased alive on March 4, 1967, and that death occurred at 2:45 a.m. from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS 23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) 24. FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE								



03847

## CERTIFICATE OF DEATH

03845

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baby Grace Hospital</u>		d. STREET ADDRESS <u>2531 Glenallen Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u>		4. DATE OF DEATH <u>3/11/67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/11/67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery County</u>	
13. FATHER'S NAME <u>Jimmy C. Humphreys</u>		14. MOTHER'S MAIDEN NAME <u>Linda Fehr</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>172-32-920</u>	
17. INFORMANT <u>Father</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary resorption atelectasis</u> DUE TO (b) <u>due to prematurity</u> DUE TO (c) <u>due to prematurity</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Subarachnoid hemorrhage</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/11</u> , 19 <u>67</u> , to <u>3/11</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>3/11</u> , 19 <u>67</u> , and that death occurred at <u>11:02 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>3/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Melvin W. Sandmyer</u>		22d. ADDRESS <u>111 Spring St. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Montg. Co., Md.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

03848

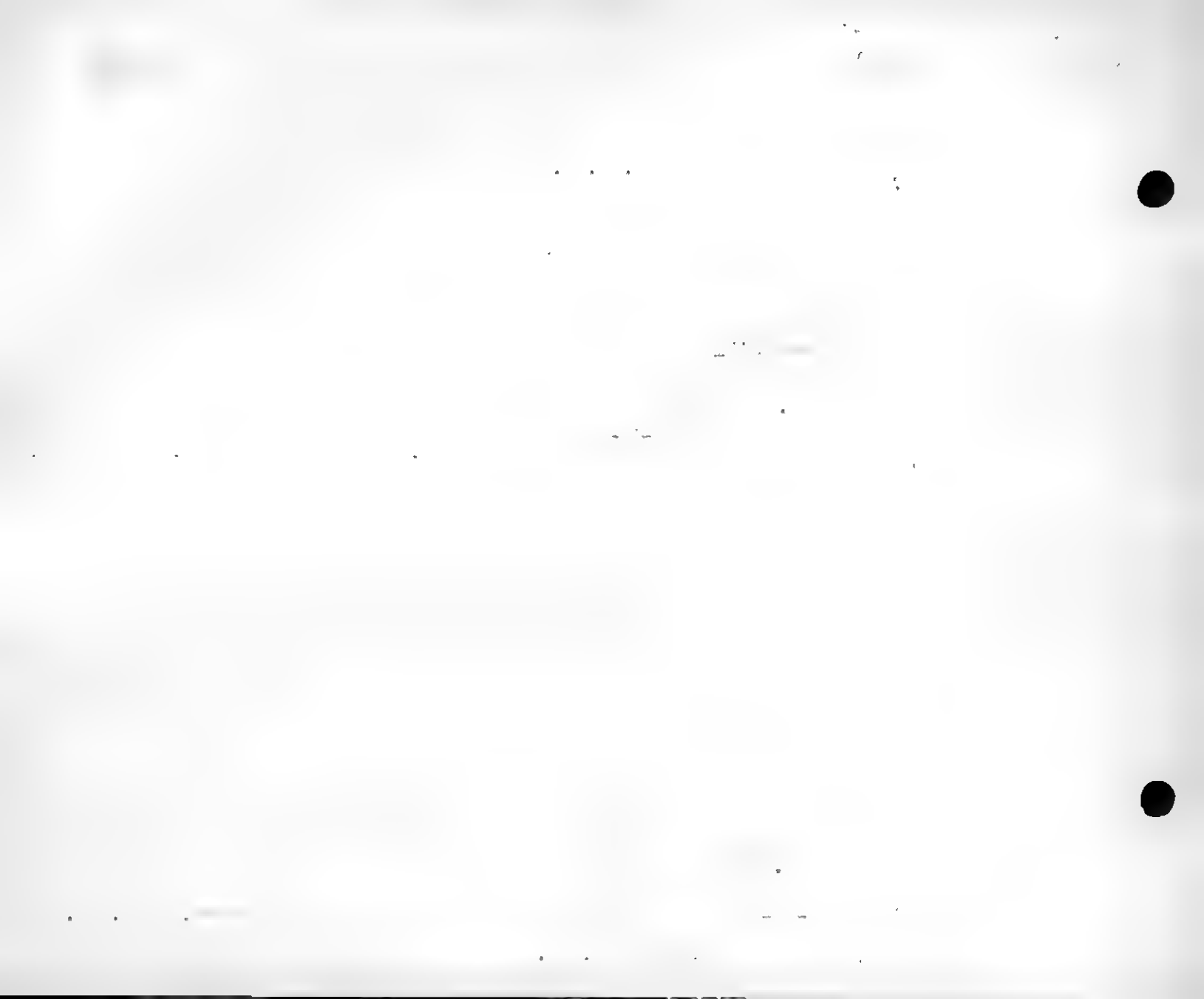
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03848

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c LENGTH OF STAY IN TB <b>D. O. A.</b>	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>		e STREET ADDRESS <b>--</b>	
3 NAME OF DECEASED (Type or print) <b>James Thomas Hungerford</b>		4 DATE OF DEATH Month <b>3</b> Day <b>10</b> Year <b>67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>11/19/06</b>
9a AGE (In years last birthday) yrs <b>60</b>		9b IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if seasonal) <b>Lumberman Sam Mill</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Lumber</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>William C. Hungerford</b>		14 MOTHER'S MAIDEN NAME <b>Lillian Pedicord</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16 SOCIAL SECURITY NO. <b>230-32-5532</b>	
17 INFORMANT <b>William C. Hungerford, Father, Germantown, Md</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Insufficiency Acute.</b> 4401 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio Vascular Disease.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>12 hr.</b> Years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John G. Ball</b> MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John G. Ball</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>3/11/67</b>	
		Address (Street, city, town, or county)	
22. DATE SIGNED			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>3-14-67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Upper Seneca</b>		23d LOCATION (City or Town) (County) (State) <b>Cedar Grove, Mont. Md.</b>	
24. FUNERAL DIRECTOR <b>Francis H. Barber</b> Laytonsville, Md.		25a REC'D BY REGISTRAR <b>MAR 15 1967</b>	
		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, forwarding the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03849

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03847

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dawsonville</u>		c LENGTH OF STAY IN b <u>15 min.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.J. Fawcett's office</u>		d STREET ADDRESS <u>R. Fd # 2</u>	
3 NAME OF DECEASED (Type or print) <u>William Henry Imes</u>		4 DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>67</u>	
5 SEX <u>M.</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jan 19 1913</u> 9 AGE (in years lost birthday) yrs <u>54</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>John W. Imes</u>		14 MOTHER'S MAIDEN NAME <u>Bertie Thompson</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> <u>4301</u> DUE TO (b) <u>Emphysema</u> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Cardio Vascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>years</u> <u>years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.		22. DATE SIGNED <u>3/16/67</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL/Specify	23b DATE THEREOF <u>3/20/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Warrick Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Martinsburg, W. Va.</u>
24 FUNERAL DIRECTOR <u>Robert L. Snowden, Rockville, Md.</u>		25a REC'D BY REGISTRAR <u>MAR 23 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>



03850

## CERTIFICATE OF DEATH

ADOLPH IRONS 03848

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> Home <i>MARYLAND</i>		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <i>md.</i> b COUNTY <i>Mund.</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Air, Md.</i>		c LENGTH OF STAY IN 1b <i>12 days</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Colonial Villa Nursing Home</i>		d STREET ADDRESS <i>7600 Carroll Ave.</i>	
3 NAME OF DECEASED (Type or print) <i>Adolph</i> First <i>Irons</i> Middle Last		4. DATE OF DEATH Month <i>3</i> Day <i>24</i> Year <i>1967</i>	
5 SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>9-12-90</i>
9 AGE (In years last birthday) <i>76</i> yrs		10 IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Painting</i>	
11 BIRTHPLACE (County & State, or foreign country) <i>New Jersey</i>		12 CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Frank L. Irons</i>		14 MOTHER'S MAIDEN NAME <i>Eelie Johnson</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Nursing Home Records</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Ventricular Fibrillation</i> DUE TO (b) <i>Metastatic Carcinoma</i> DUE TO (c) <i>Carcinoma of prostate</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 yr +</i> <i>2 yrs +</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>3-12</i> , 19 <i>67</i> , to <i>3-24</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>3-22</i> , 19 <i>67</i> , and that death occurred at <i>6:55</i> AM, from causes and on the date stated above.			
22a. SIGNATURE <i>R. H. Sandstrom</i>		22b. DATE SIGNED <i>3-24-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>R. H. Sandstrom, M.D.</i>		22d. ADDRESS <i>7701 Carroll Ave. Takoma Park, Md.</i>	
23a BURIAL CREMATION REMOVAL (Specify) <i>Buried</i>	23b. DATE THEREOF <i>March 28, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Asbarnville Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Asbarnville, Brick Township, N.J.</i>
24. FUNERAL DIRECTOR <i>Arthur Walters Washington, D.C. 20012</i>		25a. REC'D BY REGISTRAR <i>DATE 27 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR-STATE  
HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03851

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03849

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN <u>15 1/2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>16804 Oak Hill Rd.</u>				e. STREET ADDRESS <u>16804 Oak Hill Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>S.</u> Last <u>Jackson</u>				4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 12 1916</u>	
9. AGE (In years lost birthday) <u>50</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR IND. STRY <u>Cleaning</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Emme Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Wife - Emme Jackson</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> DUE TO Conditions if any, which gave rise to immediate cause (b), stating the underlying cause lost <u>Cardio Vascular Disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3/9/67</u>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3/13/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Carmel</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Robert H. Anderson</u>				25a. REC'D BY REGISTRAR <u>MAR 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John S. Ball</u>	



# MARYLAND, STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03852

## CERTIFICATE OF DEATH

03850

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>16 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>				d. STREET ADDRESS <i>7710 Brookville Road</i>	
3 NAME OF DECEASED (Type or print) First Middle Last <i>Lucy Ellen Jacobsen</i>			4. DATE OF DEATH Month Day Year <i>March 11 1967</i>		
5 SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-28-98</i>		9 AGE (n years last birthday) <i>69</i> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Coral Michigan - Montclair - USA</i>	
13. FATHER'S NAME <i>John Stewart Newell</i>			14. MOTHER'S MAIDEN NAME <i>Silworthorne, Ellen</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-54-3546</i>		17. INFORMANT <i>2735-P St. D.C. Hugh Jacobsen, son.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial Rupture</i> DUE TO (c) <i>Coronary Thrombosis</i>					INTERVAL BETWEEN ONSET AND DEATH <i>50 min</i> <i>50 min</i> <i>12 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertension</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <i>June 1953</i> to <i>3/11</i> , 1967, that (I) (we) last saw the deceased alive on <i>3/11</i> , 1967, and that death occurred at <i>11:00</i> M, from causes and on the date stated above.					
22a. SIGNATURE <i>Frank Y. Jagers Jr</i>			22b. DATE SIGNED <i>3/11/67</i>		
22c. PHYSICIAN'S NAME (Type) <i>FRANK Y. JAGGERS JR</i>			22d. ADDRESS <i>5707 WISCONSIN AVE WASH DC</i>		
23a. BURIAL (CREMATION, REMOVAL) (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>3/13/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>PARISLAWN CEM.</i>	23d. LOCATION (City or Town) (County) (State) <i>ROCKVILLE, MD.</i>		
24. FUNERAL DIRECTOR <i>JOS. GAWLER'S SONS, WASH., D.C.</i>			25a. REC'D BY REGISTRAR <i>MAR 14 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





03853

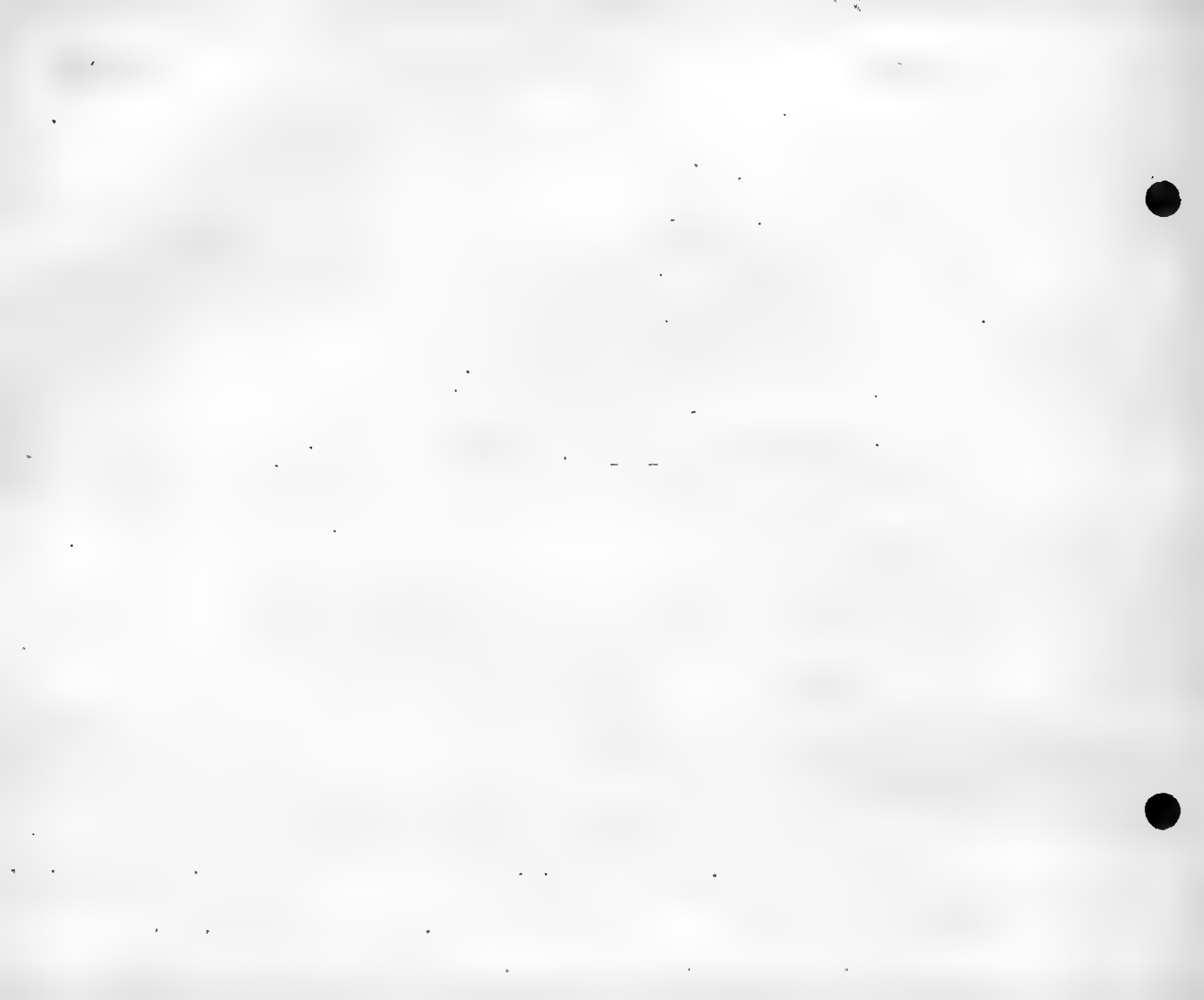
## CERTIFICATE OF DEATH

03851

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>German town</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>Box 103</u>			
3. NAME OF DECEASED (Type or print) <u>Louis Leo Jones</u>				4. DATE OF DEATH <u>March 10 1967</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/14/84</u>	
9. AGE (In years last birthday) <u>83</u> YRS		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min		12. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Joseph Jones</u>				14. MOTHER'S MAIDEN NAME <u>Isabelle Clay</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv) <u>no</u>				16. SOCIAL SECURITY NO <u>219-05-5185A</u>		17. INFORMANT <u>Estelle King</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>several months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia and pulmonary infarction</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 1966, to <u>March 10</u> , 1967, that (I) (we) last saw the deceased alive on <u>March 10</u> , 1967, and that death occurred at <u>5:15</u> P.M., from causes and on the date stated above.							
22a. SIGNATURE <u>George H. Mitchell</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> -MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>March 10, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>George H. Mitchell, M.D.</u>				22d. ADDRESS <u>11125 Rockville Pike, Rockville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/13/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Providence Meth.</u>		23d. LOCATION (City or Town) (County) (State) <u>Kemptown, Md.</u>	
24. FUNERAL DIRECTOR <u>Olin L. Molesworth, Damascus, Md.</u>				RECORDED BY REGISTRAR <u>MAR 14 1967</u>		SIGNATURE OF REGISTRAR <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

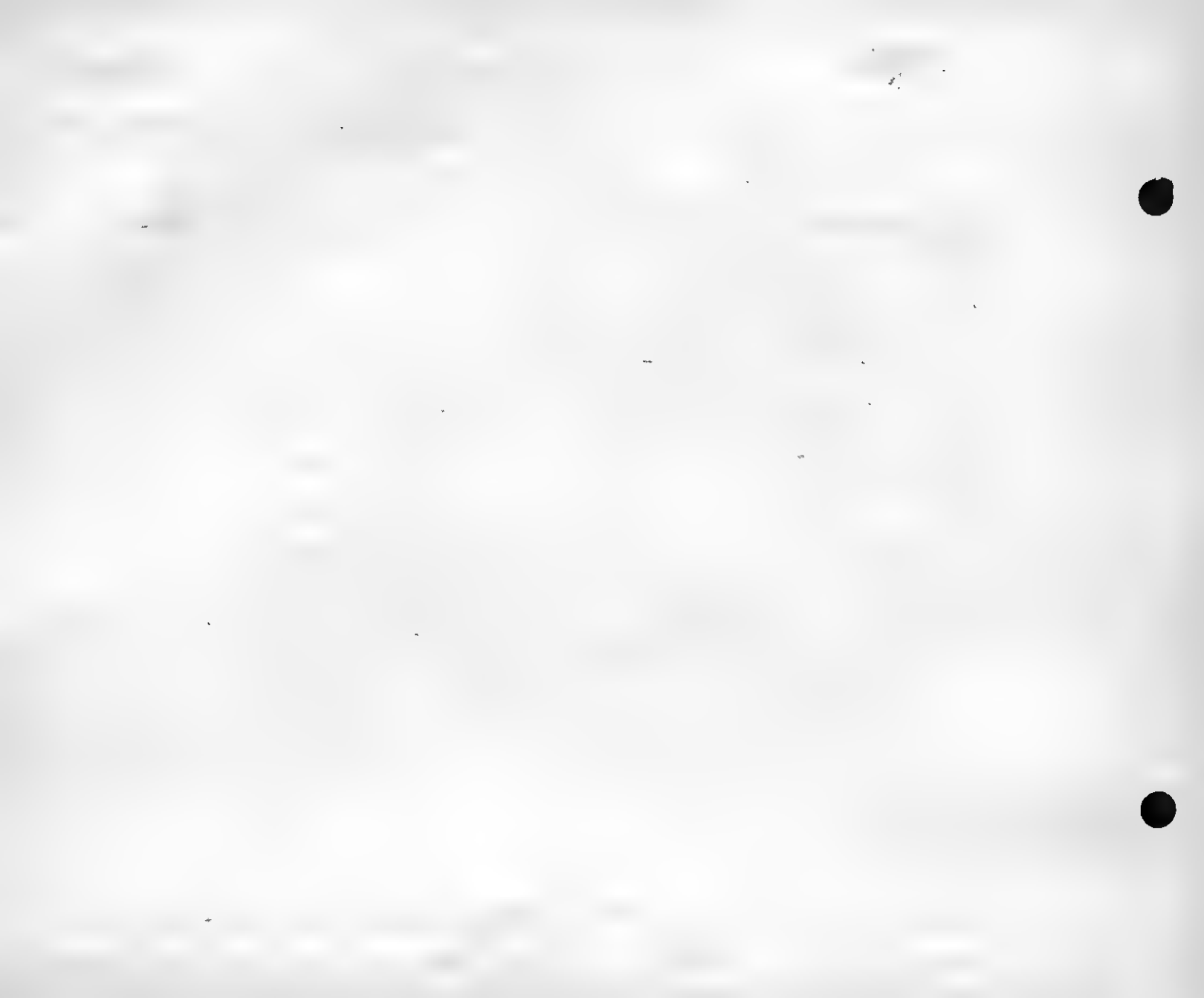
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03854

CERTIFICATE OF DEATH

03853

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Liberty Park</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Saint Hosp</u>		e. STREET ADDRESS <u>2009 Bluebridge Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>Eleanor VMN Kallinsky</u>		4 DATE OF DEATH Month <u>3</u> Day <u>21</u> Year <u>1967</u>	
5 SEX <u>female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-19-12</u> 9. AGE (In years last birthday) <u>54</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Statistical Clerk Dept of Agric</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <u>Phillip Mannheim</u>		14 MOTHER'S MAIDEN NAME <u>Naime Mannheim</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>None</u>		16 SOCIAL SECURITY NO. <u>074-05-9909</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY			
IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u>			
DUE TO <u>4201</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) <u>ARTERIOSCLEROTIC AND HYPERTENSIVE CARDIOVASCULAR DISEASE</u>			
DUE TO			
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<u>DIABETES MELLITUS, OBESITY</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 1961, to <u>MARCH 21</u> , 1967, that (I) (we) last saw the deceased alive on <u>MARCH 21</u> 1967, and that death occurred at <u>4:20 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert L. Friedman</u>		22b. DATE SIGNED <u>MARCH 21 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert A. KRICHMAR</u>		22d. ADDRESS <u>7733 MARSA AVENUE, N.W. WASHINGTON DC 20012</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/22/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>NAT'L MEM. PARK</u>		23d. LOCATION (City or town) (County) (State) <u>FALLS CHURCH VA.</u>	
24. FUNERAL DIRECTOR <u>Seashy Funeral Home</u>		25a. REC'D BY REGISTRAR <u>4217-9th</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		MAR 23 1967	



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VR A15 (4)  
20 M 1/66

03855

CERTIFICATE OF DEATH

03854

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery Convalescent Home</u>				d. STREET ADDRESS <u>400 Springbrook Drive</u>			
3 NAME OF DECEASED (Type or print) <u>Nellie</u> First <u>(J. Hanson)</u> Middle <u>Kane</u>				4 DATE OF DEATH <u>March 25</u> 19 <u>67</u>			
5 SEX <u>Female</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>1877</u>	
9 AGE (in years last birthday) <u>89</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Elthica, New York</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13 FATHER'S NAME <u>Unknown Payne</u>			
14 MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>			
16. SOCIAL SECURITY NO. <u>Yes</u>				17. INFORMANT <u>Elmer C. Kane</u> Address <u>400 Springbrook Drive Silver Spring, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerosis Generalized</u> DUE TO (c) <u>15 yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>7/29</u> , 19 <u>66</u> , to <u>3/25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/25</u> 19 <u>67</u> , and that death occurred at <u>9:30</u> AM, from causes on and on the date stated above.							
22a. SIGNATURE <u>M. B. Queen</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. B. QUEEN</u>				22d. ADDRESS <u>44 Univ. Blvd. W. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar 29, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Colesville Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Colesville, Maryland</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas Warner E. Humphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>48434 Georgia Avenue Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



Cleared by Dr. John Ball

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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03856

CERTIFICATE OF DEATH

03855

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c LENGTH OF STAY IN TOWN <b>DOA</b> d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Montgomery</b> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d STREET ADDRESS <b>8201 16th St.</b> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Benjamin</b> First Middle Last 4 DATE OF DEATH <b>March 1 19 67</b> Month Day Year		5 SEX <b>Male</b> 6 COLOR OR RACE <b>White</b> 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8 DATE OF BIRTH <b>9/22/88</b> 9 AGE (In years last birthday) yrs <b>78</b> IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance</b> 10b KIND OF BUSINESS OR INDUSTRY <b>Insurance</b> 11 BIRTHPLACE (County & State, or foreign country) <b>New York City, N.Y.</b> 12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13 FATHER'S NAME <b>Abraham Kay</b> 14 MOTHER'S MAIDEN NAME <b>Ida</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1917-18</b> 16 SOCIAL SECURITY NO <b>579 42 9179</b> 17 INFORMANT <b>Son, Marvin Kay</b> Address <b>Home address</b>		18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Coronary Arterio-sclerosis</b> <b>10 yrs</b> (c) <b>Ess. Benign Hypertension</b> <b>16 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>1950</b> , to <b>3-1, 1967</b> , that (I) (we) lost the deceased alive on <b>3-1, 1967</b> , and that death occurred at <b>8:30 P.M.</b> , from causes and on the date stated above. 22a. SIGNATURE <b>Leroy Robins</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>3-1-67</b> 22c. PHYSICIAN'S NAME (Type) <b>LEROY ROBINS</b> 22d. ADDRESS <b>2480-16th ST. N.W. Wash. DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b> 23b. DATE THEREOF <b>3/3/67</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Ohev Shalom-Talmud Torah</b> 23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>		24. FUNERAL DIRECTOR <b>Bernard Danzansky &amp; Sons</b> 25a. REC'D BY REGISTRAR <b>6 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





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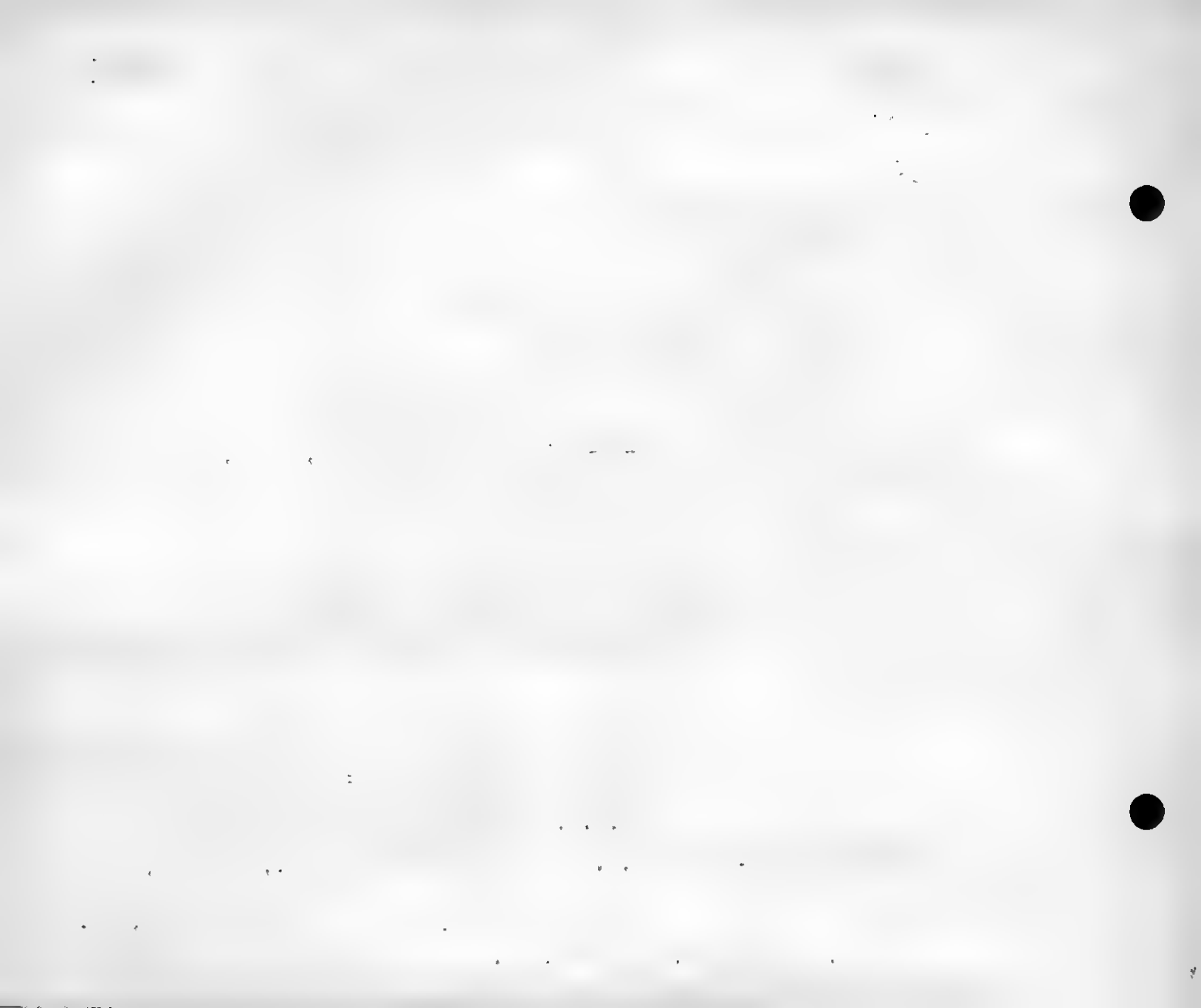
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03857

03856

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		d. STREET ADDRESS <b>RFD 1</b>	
3 NAME OF DECEASED (Type or print) <b>Turner J Keith</b>		4 DATE OF DEATH Month <b>3</b> Day <b>22</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>10/11/85 6/24/85</b>
9 AGE (in years last birthday) <b>81</b>		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurseryman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nursery</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Keith</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Andrew</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>218-30-4243</b>	
17 INFORMANT <b>Hospital Records, Olney, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4201 Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Acute Myocardial Infarct, anterior</b> (c) <b>Arteriosclerotic Heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>3/22</b> , 19 <b>67</b> , to <b>3/22</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3/22</b> , 19 <b>67</b> , and that death occurred at <b>7:20 P</b> M, from causes and on the date stated above			
22a SIGNATURE <b>James P. Kerr, M.D.</b>		22b DATE SIGNED <b>3/23/67</b>	
22c PHYSICIAN'S NAME (Type) <b>James P. Kerr M.D.</b>		22d ADDRESS <b>26618 Ridge Rd., Damascus, Maryland</b>	
23a BURIAL, CREMATION, REMOVA. (Specify) <b>Burial</b>		23b DATE THEREOF <b>5/26/67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Bethesda Meth.</b>		23d LOCATION (City or town) (County) (State) <b>Browningsville, Md.</b>	
24 FUNERAL DIRECTOR <b>Olin L. Molesworth, Damascus, Md.</b>		25a REC'D BY REGISTRAR <b>MAR 28 1967</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03858

CERTIFICATE OF DEATH

03857

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NAVAL HOSPITAL</b>				d. STREET ADDRESS <b>306 HALSEY ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MICHAEL ROBERT KELLY</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>1</b> Year <b>1967</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUC</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4 AUG 53</b>		9. AGE (In years last birthday) <b>13</b> yrs		IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>67</b> Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>ANN ARUNDEL, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ROBERT C. KELLY</b>				14. MOTHER'S MAIDEN NAME <b>PATRICIA MC CORMICK</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>306 HALSEY ROAD, ANNAPOLIS, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal shutdown</b> DUE TO <b>Acute lymphoblastic leukemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hemorrhagic diathesis</b>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from <b>Feb. 27</b> , 19 <b>67</b> , to <b>Mar. 1</b> , 19 <b>67</b> , that (H) (we) last saw the deceased alive on <b>Mar. 1</b> , 19 <b>67</b> , and that death occurred at <b>211A M.</b> , from causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED <b>2 March 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>D. R. Foreman, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE THEREOF <b>3/3/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Anne's Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>ANNAPOLIS, ANN ARUNDEL, MD.</b>	
24. FUNERAL DIRECTOR <b>John M. Taylor, 147-149 Gloucester St., ANNAPOLIS, MD.</b>				25a. RECD BY REGISTRAR <b>MAR 3 1967</b>		25b. REGISTRAR'S SIGNATURE 	



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VR A15 (4)  
25M 1/67

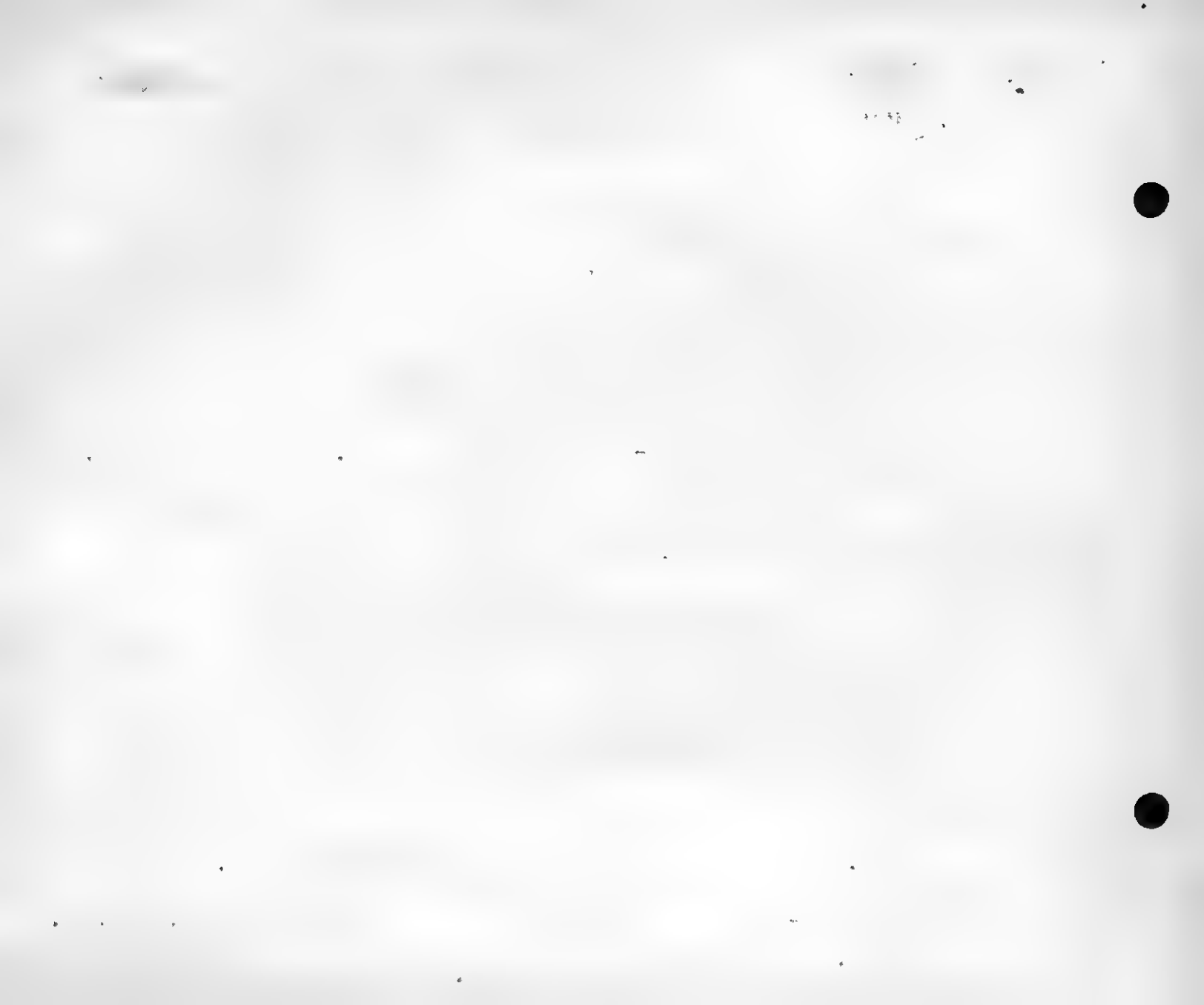
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03859

03858

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		d. STREET ADDRESS <b>6 Wesley Court</b>	
3. NAME OF DECEASED (Type or print) <b>Mattie C. Kemp</b>		4. DATE OF DEATH <b>Mar. 31 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-19-86</b>
9. AGE (In years last birthday) <b>80 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Curtis</b>		14. MOTHER'S MAIDEN NAME <b>Harriet Brown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>-</b>	
17. INFORMANT <b>Montgomery Gen. Hospital</b>		Address <b>Olney, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Inter-Cerebral Hemorrhage</b> DUE TO (b) <b>Arteriosclerosis - Gen.</b> DUE TO (c) <b>lost.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a)) <b>① Pneumonia - Bronchial ② H. H. D.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. pm 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3-18 1967</b> to <b>3-31 1967</b> , that (I) (we) last saw the deceased alive on <b>3-30 1967</b> , and that death occurred at <b>6:30 am</b> from causes and on the date stated above			
22a. SIGNATURE <b>Jack Schumacher</b> M.D.		22b. DATE SIGNED <b>3-31-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Jack Schumacher</b>		22d. ADDRESS <b>Gaithersburg, Md.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-3-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Laytonsville</b>	23d. LOCATION (City or Town) (County) (State) <b>Laytonsville, Mont. Md.</b>
24. FUNERAL DIRECTOR <b>Francis H. Barber Funeral Home</b> <b>Laytonsville Md.</b>		25a. REC'D BY REGISTRAR <b>APR 4 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (5)  
20 M 1/66

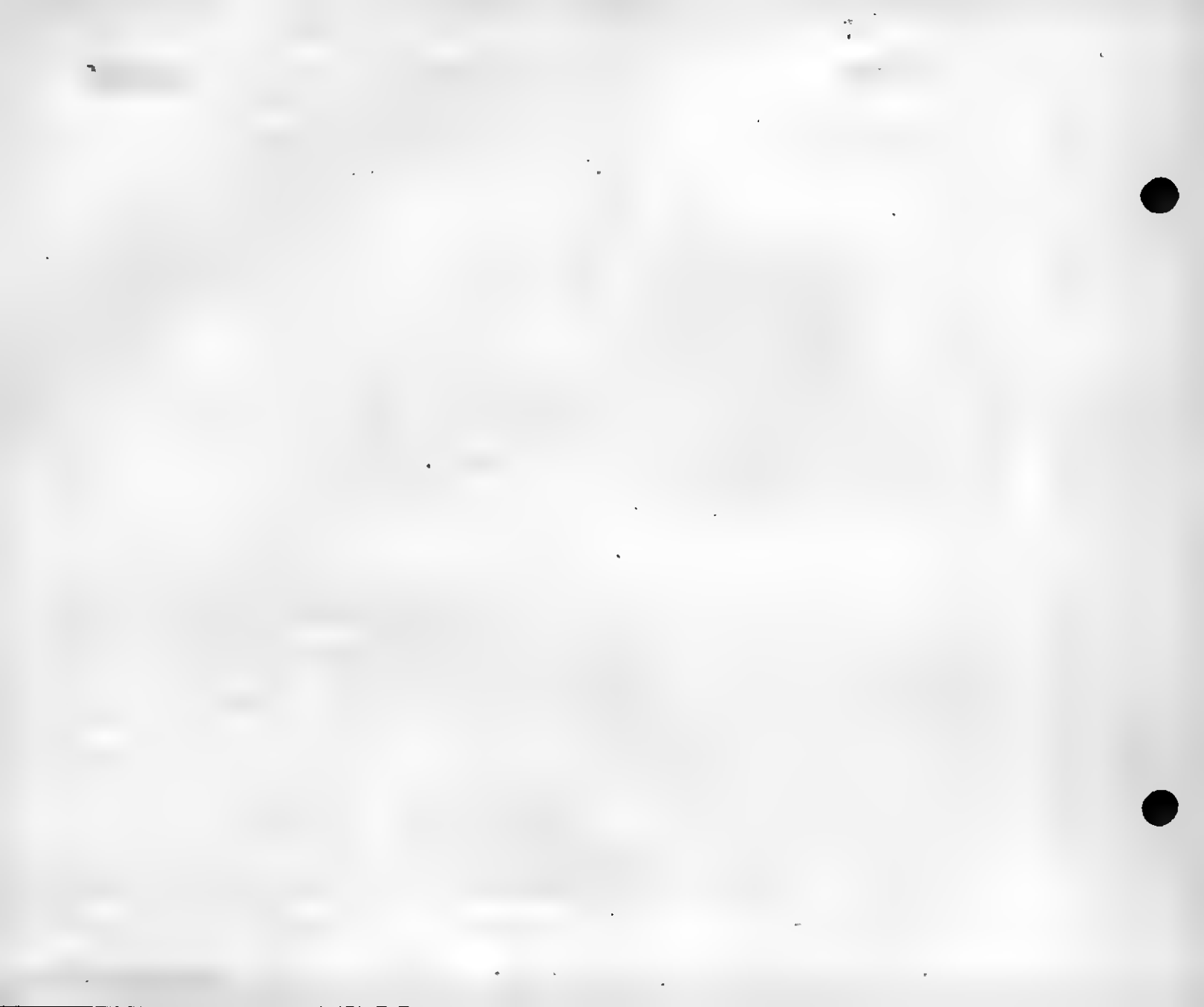
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03860

CERTIFICATE OF DEATH

03859

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home</u>				d. STREET ADDRESS <u>5350 Edgemoor Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>INEZ</u> Middle <u>B.</u> Last <u>KIRBY</u>				DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-18-82</u>	9. AGE (In years last birthday) <u>84</u> yrs	IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u>15</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Franklin Lin</u>				14. MOTHER'S MAIDEN NAME <u>Susan Thompson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>Husband</u> <u>Paul L. Kirby</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thromboses, multiple, and</u> DUE TO <u>Left femoral artery thrombosis with</u> (b) <u>gangrene left leg</u> DUE TO <u>Arteriosclerosis, general, very severe</u> (c) <u>5 yrs +</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u> <u>72 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Senility, very advanced due to arteriosclerosis 7 yrs.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1951</u> , to <u>3-7-1967</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>3-6-1967</u> , and that death occurred at <u>2:54 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Stewart Clapp</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>3-7-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp MD</u>				22d. ADDRESS <u>4740 Chevy Chase Dr. Chevy Chase 15 Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-10-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>St. Michaels, Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Md.</u>				25. REC'D BY REGISTRAR <u>MAR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

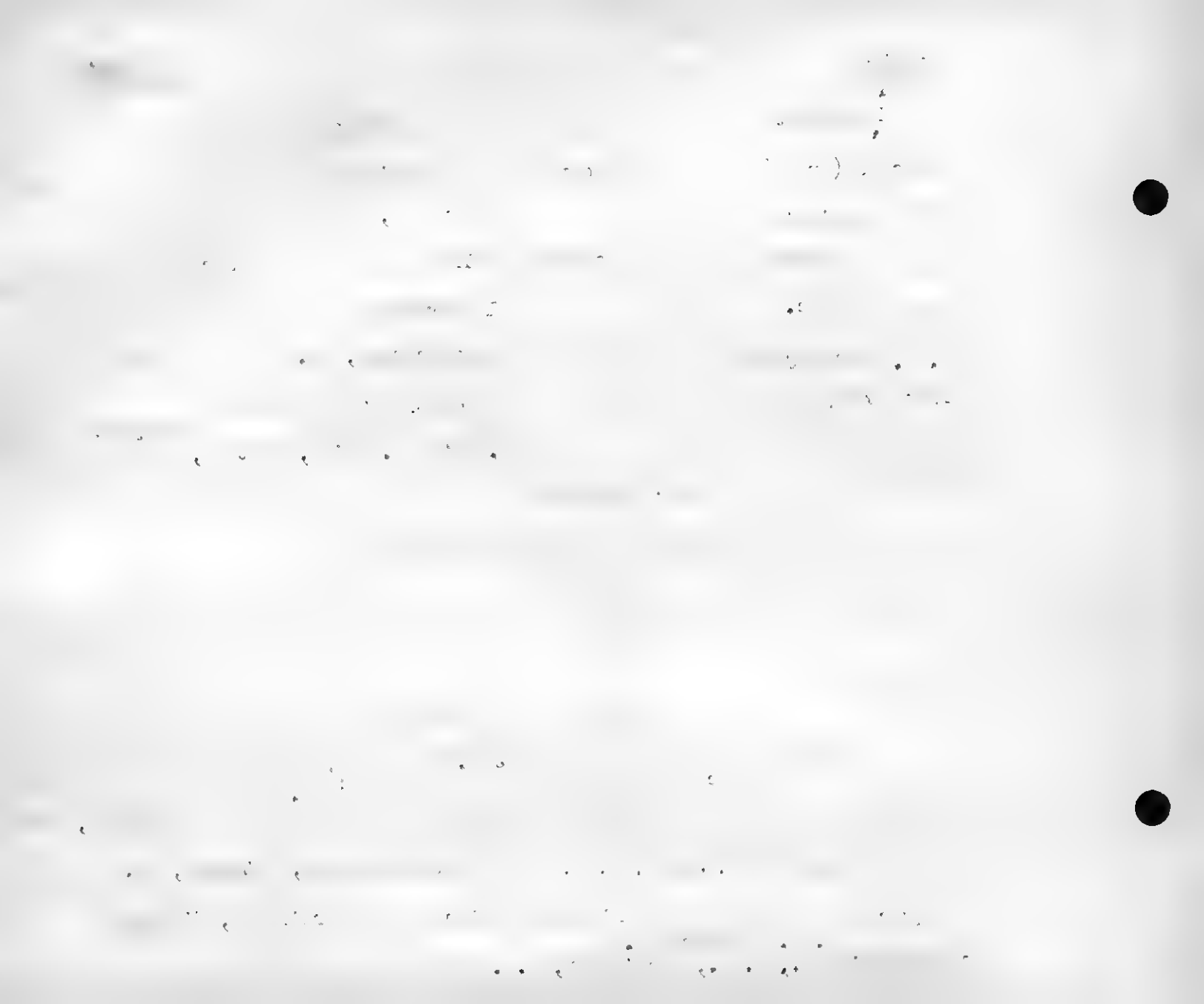
03861

CERTIFICATE OF DEATH

03860

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b> c. LENGTH OF STAY IN b <b>72 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Rawlings</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route 3, Box 206</b>	
3 NAME OF DECEASED (Type or print) <b>Thomas Alexander KLINE</b>		4 DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>13 November 1945</b>
9. AGE (In years last birthday) yrs <b>21</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Marine Corps</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>Locaconing, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Titus Leroy Kline</b>		14. MOTHER'S MAIDEN NAME <b>Jean Caldwell Spier</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO	
17 INFORMANT <b>Rawlings</b> <b>Mr. Titus L. Kline, Route 3, Box 206</b>		Address <b>Maryland</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO (b) <b>Embryonal carcinoma of testes</b> stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>Jan. 7</b> , 19 <b>67</b> , to <b>March 20</b> , 19 <b>67</b> , that (we) lost saw the deceased alive on <b>March 20</b> , 19 <b>67</b> , and that death occurred at <b>4:00 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Lawrence A. Jones</i>		22b. DATE SIGNED <b>March 21, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence A. Jones, M. D.</b>		22d ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/24/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or town) (County) (State) <b>Arlington, Virginia</b>
24 FUNERAL DIRECTOR <b>W. W. Chambers Co.</b>		25a. RECORDED BY REGISTRAR <b>23 1967</b>	
1400 Chapin St., N. W., Washington, D.C.		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03862

## CERTIFICATE OF DEATH

03861

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb <b>47 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> d. STREET ADDRESS <b>4834 Drummond Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Marvin</b> Last <b>Kniep</b>		4. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>18 November 1931</b>
9. AGE (in years last birthday) <b>35 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Henry William Kniep</b>	
14. MOTHER'S MAIDEN NAME <b>Laura Hook</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Not available</b>		17. INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, Bethesda, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hodgkin's Disease</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>7 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20a. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>13 January, 1967</b> , to <b>1 March, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>1 March 1967</b> , and that death occurred at <b>1:50 M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Martin H. Cohen</b>		22b. DATE SIGNED <b>1 March 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Martin H. Cohen, MD.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-3-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Lutheran Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Red Hill, Penna.</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25. REC'D BY REGISTRAR <b>MAR 8 1967</b>	
25a. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

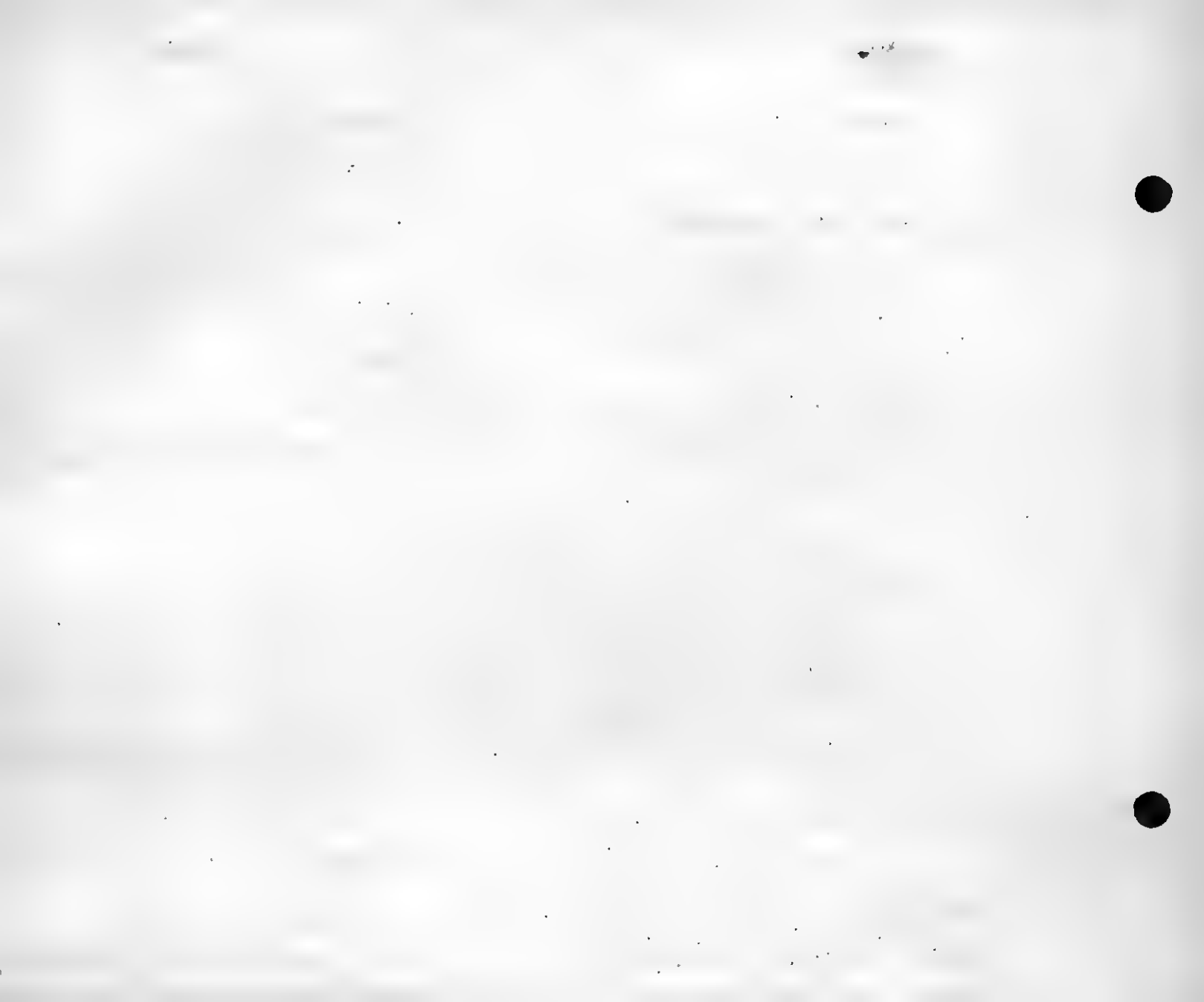


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*Cleared - Med. Exam by Dr. Shapiro*

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <u>Montgomery</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> <b>a. STATE</b> <u>Maryland</u> <b>b. COUNTY</b> <u>Prince George</u>							
<b>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</b> <u>Silver Spring</u>		<b>c. LENGTH OF STAY IN 1b</b> <u>22 hours</u>		<b>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</b> <u>Beltsville</u>				<b>d. STREET ADDRESS</b> <u>11368 Cherry Hill Road #304</u>	
<b>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</b> <u>Holy Cross Hospital</u>		<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED (Type or print)</b> <u>Soren</u> <b>First</b> <u>Thomas</u> <b>Middle</b> <u>Koontz</u> <b>Last</b>		<b>4. DATE OF DEATH</b> <u>March 24</u> <b>Month</b> <u>1967</u> <b>Day</b> <u>19</u> <b>Year</b>							
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>April 20, 1965</u>		<b>9. AGE (In years last birthday)</b> <u>2</u> <b>1 yrs.</b> <u>1</u> <b>Months</b> <u>0</u> <b>Days</b> <u>0</u> <b>Hours</b> <u>0</u> <b>Min.</b> <u>0</u>	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <u>None</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <u>Indiana</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Thomas W. Koontz</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Phyllis Hart</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Mc Comb Funeral Home</u>		<b>Address</b> <u>1140 Lake Avenue East Wayne, Indiana</u>			
<b>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</b>									
<b>PART I. DEATH WAS CAUSED BY:</b>									
<b>IMMEDIATE CAUSE (a)</b> <u>Pneumonia</u>									
<b>CONDITIONS, If any, which gave rise to immediate cause (a), stating the underlying cause last.</b>									
<b>DUE TO (b)</b> <u>Bacterial infection</u>									
<b>DUE TO (c)</b> <u>60 hrs.</u>									
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>									
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>DR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)									
<b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b>									
<b>20c. TIME OF INJURY</b> <b>Month, Day, Year</b> <u>19</u>		<b>20d. INJURY OCCURRED</b> <b>While at work</b> <input type="checkbox"/> <b>Not While at work</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b>		<b>20f. (City or town)</b> <u>East Wayne</u> <b>(County)</b> <u>Indiana</u> <b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>3/23, 1967</u> to <u>3/24, 1967</u>, that (I) (we) last saw the deceased alive on <u>3/23, 1967</u>, and that death occurred at <u>PM</u>, from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <u>Melvin Shapiro</u> <b>M.D.</b>						<b>22b. DATE SIGNED</b> <u>3/24/67</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Melvin Shapiro, M.D.</u>						<b>22d. ADDRESS</b> <u>1040 University Blvd. W., Silver Spring, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Trans-burial</u>		<b>23b. DATE THEREOF</b> <u>Mar 28, 1967</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Greenlawn Cemetery</u>		<b>23d. LOCATION (City, town or county)</b> <u>East Wayne, Indiana</u> <b>(State)</b>			
<b>24. FUNERAL DIRECTOR</b> <u>John B. Thomas</u>		<b>ADDRESS</b> <u>8434 Georgia Avenue</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u>		<b>25b. REGISTRAR'S SIGNATURE</b>			
<b>VR A15 (4)</b> <b>20M 1/65</b>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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*Charles E. Coleman - John Paul MD.*

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03864

CERTIFICATE OF DEATH

03863

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA, MD.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Md.</b>	
c. LENGTH OF STAY IN 1b <b>1 Yr. 3 mths.</b>		d. STREET ADDRESS <b>6036 Rossmore Drive</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RESMOR SANITARIUM &amp; HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Fern Kost</b>		4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>14 July 1895</b>
9. AGE (In years last birthday) <b>71 yrs</b>		10. IF UNDER 1 YEAR Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min. <b>71</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) <b>Illinois</b>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ford Overstreet</b>		14. MOTHER'S MAIDEN NAME <b>Isabelle Hillard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> DUE TO <b>TAUI</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic vascular disease</b> (c) <b>Chronic pulmonary emphysema</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic pulmonary emphysema</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>Sept.</b> , 1964, to <b>March</b> , 1967, that (2) (we) last saw the deceased alive on <b>Jan 31</b> , 1967, and that death occurred at <b>9:00 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>James R. Coleman MD</b>		22b. DATE SIGNED <b>3/7/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES R. COLEMAN MD</b>		22d. ADDRESS <b>9241 COLUMBIA BLVD SILVER SPRING MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>3-8-67</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>Roselawn Mem. Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Springfield Illinois.</b>	
24. FUNERAL DIRECTOR <b>HARTON Funeral Home</b>		25a. REC'D BY REGISTRAR <b>MAR 15 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles E. Coleman</b>		25c. REGISTRAR'S SIGNATURE	





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

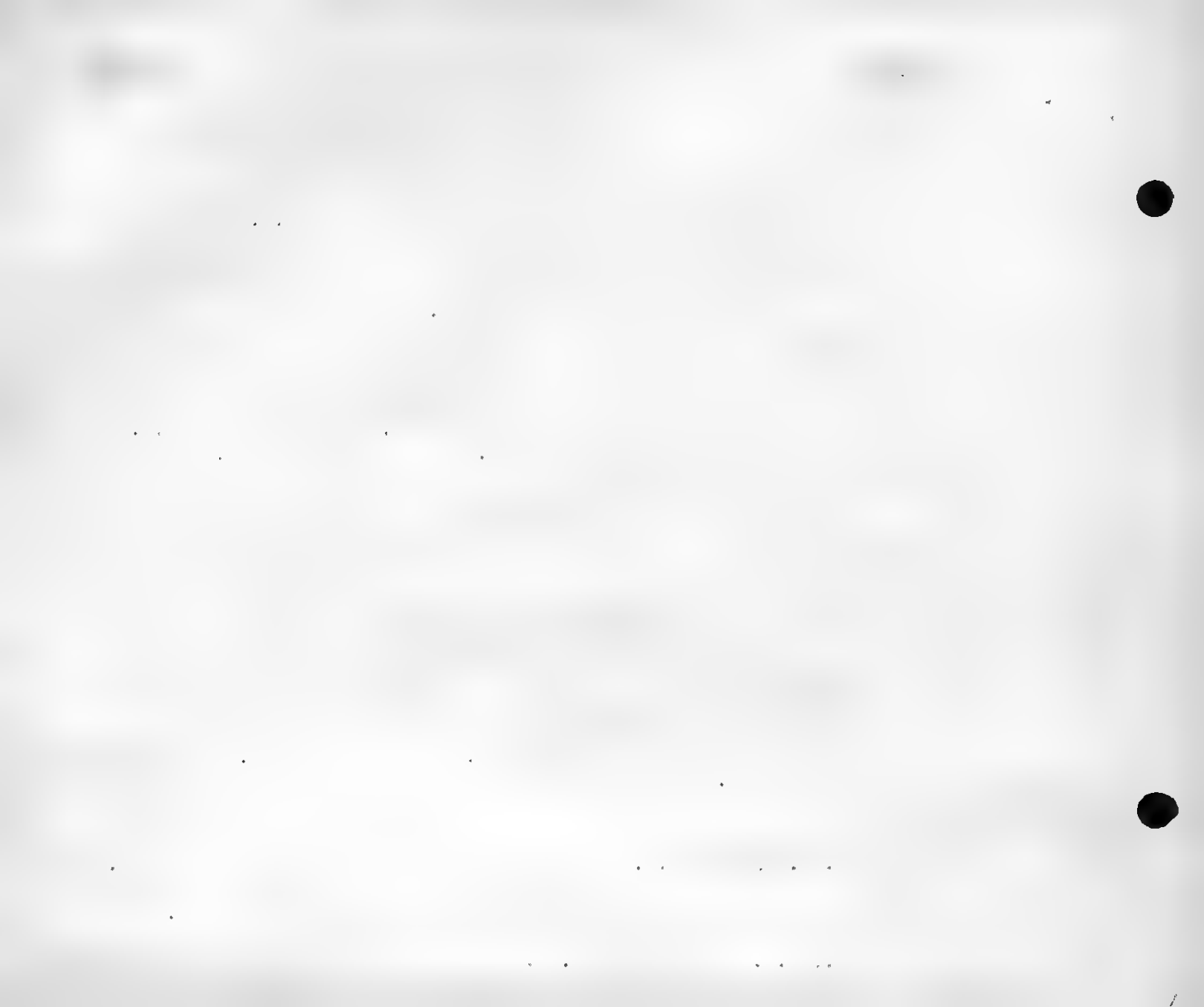
**03865**

**CERTIFICATE OF DEATH**

**03864**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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<b>1 PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>107 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Naval Hospital</u>				<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington,</u> d. STREET ADDRESS <u>121 U Street, N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
<b>3 NAME OF DECEASED</b> (Type or print) <u>Charlotte Hicks LAGUERTA</u> First Middle Last <b>5 SEX</b> <u>Female</u> <b>6 COLOR OR RACE</b> <u>Negro</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8 DATE OF BIRTH</b> <u>Sept. 7, 1896</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9 AGE</b> (In years last birthday) <u>70</u> yrs <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____ <b>11 BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u> <b>12 CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>				<b>4 DATE OF DEATH</b> <u>MARCH</u> <u>9</u> <u>19</u> <u>67</u> Month Day Year <b>13. FATHER'S NAME</b> <u>Phillip Hicks</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u> <b>15 WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <b>16 SOCIAL SECURITY NO</b> <u>579 54 0633</u> <b>17. INFORMANT</b> <u>N.W., Washington</u> Address <u>D.C. Mrs. Emma Ford Washington, 402 Shepherd St.</u>																			
<b>18 CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>Carcinoma Ovaries</u> IMMEDIATE CAUSE (a) <u>1150</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ <b>19 WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
<b>MEDICAL CERTIFICATION</b> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td colspan="2" style="vertical-align: top;"> <b>20a ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/>  <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH                      (IF EITHER, NOTIFY MEDICAL EXAMINER)                 </td> <td colspan="6" style="vertical-align: top;"> <b>20b DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) _____                 </td> </tr> <tr> <td colspan="2" style="vertical-align: top;"> <b>20c TIME OF INJURY</b> Month, Day, Year                      Hour a.m. _____ p.m. _____ 19____                 </td> <td colspan="2" style="vertical-align: top;"> <b>20d. INJURY OCCURRED</b>                      While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> </td> <td colspan="2" style="vertical-align: top;"> <b>20e PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____                 </td> <td colspan="2" style="vertical-align: top;"> <b>20f</b> (City or town) _____ (County) _____ (State) _____                 </td> </tr> </table>								<b>20a ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) _____						<b>20c TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. _____ 19____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f</b> (City or town) _____ (County) _____ (State) _____	
<b>20a ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) _____																					
<b>20c TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. _____ 19____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f</b> (City or town) _____ (County) _____ (State) _____																	
<b>21 I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Nov. 22</u> , 19 <u>66</u> , to <u>Mar. 9</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Mar. 9</u> , 19 <u>67</u> , and that death occurred at <u>330AM</u> , from causes and on the date stated above.																							
<b>22a SIGNATURE</b> <u>R. J. Kinney</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>R. J. KINNEY, M.D.</u>				<b>22b DATE SIGNED</b> <u>March 9, 1967</u> <b>22d. ADDRESS</b> <u>Naval Hospital, Bethesda, Md.</u>																			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b DATE THEREOF</b> <u>3-13-1967</u>		<b>23c NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u>		<b>23d LOCATION</b> (City or Town) _____ (County) _____ (State) <u>Arlington, Va.</u>																	
<b>24. FUNERAL DIRECTOR</b> <u>Jarvis Funeral Home</u> ADDRESS <u>1432 U St., N.W., Washington, D. C.</u>				<b>25a REC'D BY REGISTRAR</b> <u>March 13 1967</u>		<b>25b REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>																	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03866

03865

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>24h.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9818 Cahrell Terrace</u>			d. STREET ADDRESS <u>9704 Armistead Rd.</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Catherine Kelly</u>			4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1967</u>		
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22, 1874</u>		9. AGE (In years last birthday) <u>92</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hw.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Lynch</u>			14. MOTHER'S MAIDEN NAME <u>Anne Roach</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	17. INFORMANT Address <u>Daughter Katherine Dougherty</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> <u>Coronary Insufficiency Acute</u> DUE TO (b) <u>Cardio Vascular Disease -</u> DUE TO (c) <u>Sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John S. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED	
EXAMINER'S NAME (Type) <u>John G BALL</u>		ASSISTANT MED. CA. EXAMINER <input type="checkbox"/>		<u>3/5/67</u>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>MAR. 5, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Catholic</u>	23d. LOCATION (City or town) (County) (State) <u>Newton MD</u>		
24. FUNERAL DIRECTOR <u>W. J. Altom</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 7 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. J. Judge</u>		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03866

FOR STATE HEALTH DEPT

03867

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN 1b <i>D.O.A.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash. San. &amp; Hospital</i>		d. STREET ADDRESS <i>13505 Turkey Branch</i>	
3. NAME OF DECEASED (Type or print) <i>Raymond Elsworth Lawson</i>		4. DATE OF DEATH Month <i>3</i> Day <i>23</i> Year <i>1967</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-27-17</i>
9. AGE (In years, months, days) <i>49</i> yrs		10. IF UNDER 1 YEAR Months <i>23</i> Days <i>23</i> Hours <i>19</i> Min <i>67</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Army Eng Corp</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Zachariah B. Lawson</i>		14. MOTHER'S MAIDEN NAME <i>Martha Hickson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>214-03-8527</i>	
17. INFORMANT <i>Item #2 Mrs Vivian Lawson (wife)</i>		18. MARVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <i>4201</i> IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i> DUE TO (b) <i>Severe Coronary Artery Heart Disease</i> DUE TO (c) <i>Heart Disease</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Reap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>BELDEN R. REAP, M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <i>3/23/1967</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL (CREMATION, REMOVAL (Specify)) <i>burial</i>		23b. DATE THEREOF <i>3/27/67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln</i>		23d. LOCATION (City or town) (County) (State) <i>Prince George's County Md.</i>	
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>		25a. REC'D BY REGISTRAR <i>MAR 27 1967</i>	
ADDRESS <i>1311 "oc". Pike Rockville, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



03868

CERTIFICATE OF DEATH

03867

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Montana</b> b. COUNTY <b>Daniels</b> ✓			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY in 1b <b>10 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Scobey</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>				d. STREET ADDRESS <b>Box 561</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Gerald</b> Middle <b>Emanuel</b> Last <b>Lebel</b>				4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <b>11 July 1930</b>	9. AGE (in years lost birthday) <b>36 yrs</b>	F UNDER 1 YEAR Months <b>24</b> Days <b>24</b> Hours <b>00</b> M.n. <b>00</b>		IF UNDER 24 HRS. Hours <b>00</b> M.n. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Montana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Adlar Lebel</b>				14. MOTHER'S MAIDEN NAME <b>Lucy Girard</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Not available</b>		17. INFORMANT <b>The Medical Record</b> address <b>The Clinical Center, Bethesda, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-respiratory failure</b> DUE TO (b) <b>Liver failure</b> DUE TO (c) <b>Congestive heart failure</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>10 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>8 months opost-operative open heart surgery(aortic &amp; mitral valve/ replacement)</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m. <b>19</b>		20b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>14 March, 1967</b> to <b>24 March, 1967</b> , that (s) (we) last saw the deceased alive on <b>24 March, 1967</b> , and that death occurred at <b>8:00</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Hamner Hannah III</b>				22b. DATE SIGNED <b>25 March 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Hamner Hannah III, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/29/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Scobey Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Scobey, Montana</b>	
24. FUNERAL DIRECTOR <b>Warner E. Humphrey, Inc.</b>				25a. REC'D BY REGISTRAR <b>29 MAR 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





03868

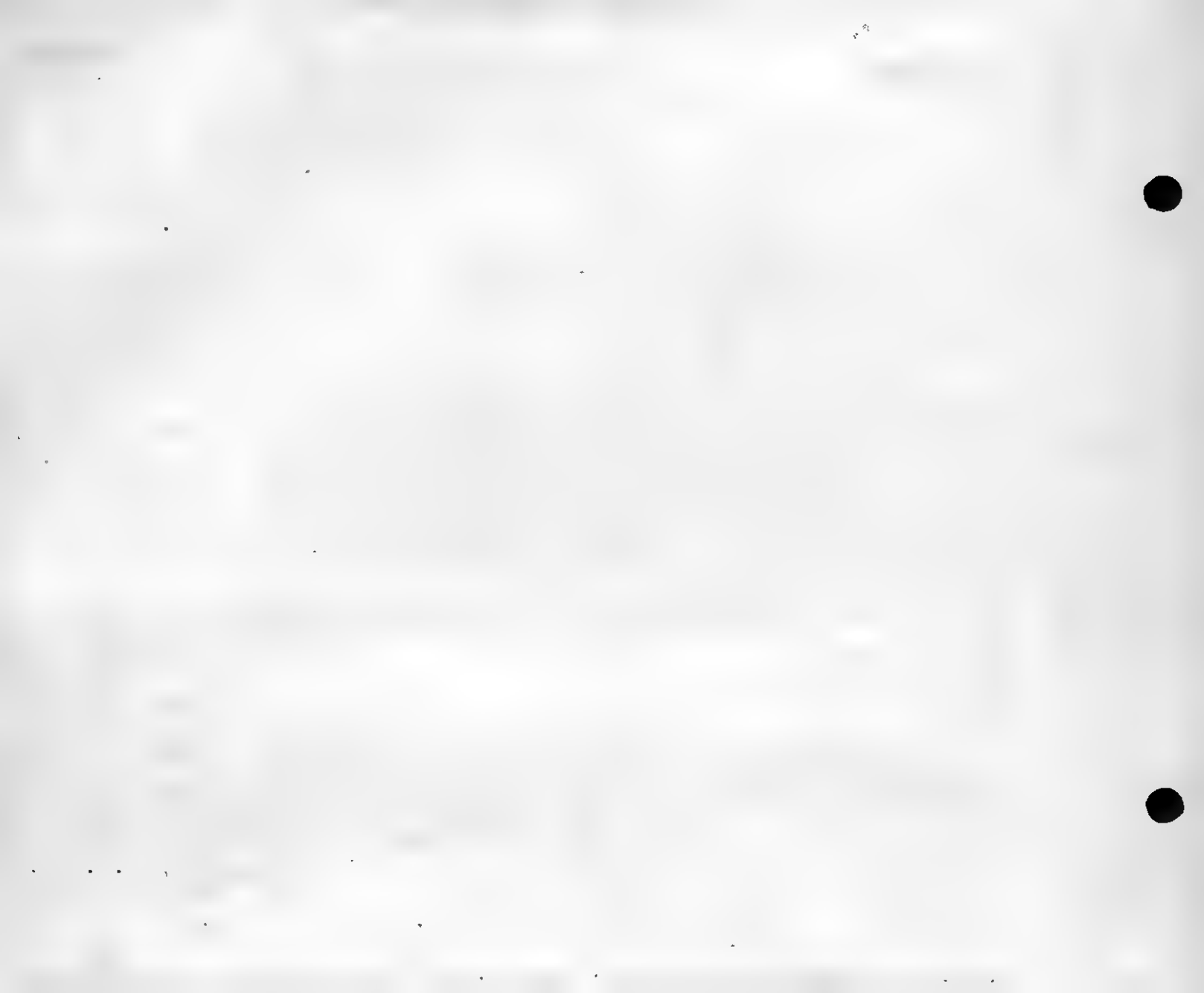
03869

## CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District Of Columbia</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	c. LENGTH OF STAY IN 1b <b>27 Days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>7706 13th Street N.W.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Harold V. Lese</b>		4. DATE OF DEATH Month <b>March</b> Day <b>16</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 10 1907</b>
9. AGE (In years last birthday) <b>59 yrs</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>9</b>	11. IF UNDER 24 HRS. Hours <b>5</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Law</b>	11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Samuel</b>	
14. MOTHER'S MAIDEN NAME <b>-----</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Peter Lese, son</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatous (undifferentiated)</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Pancreatic Pseudocyst</b> (b) <b>Pancreatic Pseudocyst</b> (c) <b>-----</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>(1)</b> (this hospital) attended the deceased from <b>Feb 17, 1967</b> to <b>March 16, 1967</b> , that <b>(1)</b> (we) last saw the deceased alive on <b>March 16, 1967</b> , and that death occurred at <b>11:50 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Gene U. Cohen</b> MD		22b. DATE SIGNED <b>March 17, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Gene Cohen</b>		22d. ADDRESS <b>1106 Spring Street, S.S. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/19/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Adas Israel Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Wash., D.C.</b>
24. FUNERAL DIRECTOR <b>Bernard Danzansky &amp; Sons St. NW, Wash. DC</b>		25a. REC'D BY REGISTRAR <b>APR 20 1967</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR STATE  
HEALTH DEPT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03870

03869

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Montgomery</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c LENGTH OF STAY in 1b <b>4 years</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll Hall Nursing Home</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>KATHERINE BRAGONIER LEWIS</b>		4 DATE OF DEATH Month Day Year <b>March 14, 1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Sept. 9, 1871</b>
9 AGE (In years last birthday) yrs <b>95</b>		10 IF UNDER 1 YEAR Months Days Hours Min. <b>95</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13 FATHER'S NAME <b>Alfred C. Bragonier</b>		14 MOTHER'S MAIDEN NAME <b>Elizabeth Magee</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>216-46-0289</b>	
17 INFORMANT <b>5000 Dorset Ave. Virginia S. Arnold, Chevy Chase, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>11330 Cardiac Arrest.</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular Disease.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b> <b>years</b>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fracture of Hip -</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18) <b>Fall in Nursing Home -</b>	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>Morning 1/29 1967</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Nursing Home - Kensington Montgomery Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>March 15, 1967</b> <b>Bethesda, Md.</b>	
ACTUAL SIGNATURE <b>John G. Ball</b> EXAMINER'S NAME (Type) <b>JOHN G. BALL</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL (CREMATION, REMOVAL) (Specify) <b>Burial</b>	23b DATE THEREOF <b>3-17-67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>
24 FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a REC'D BY REGISTRAR <b>MAR 22 1967</b> 25b REGISTRAR'S SIGNATURE <b>John Charles Judge</b>	

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03871

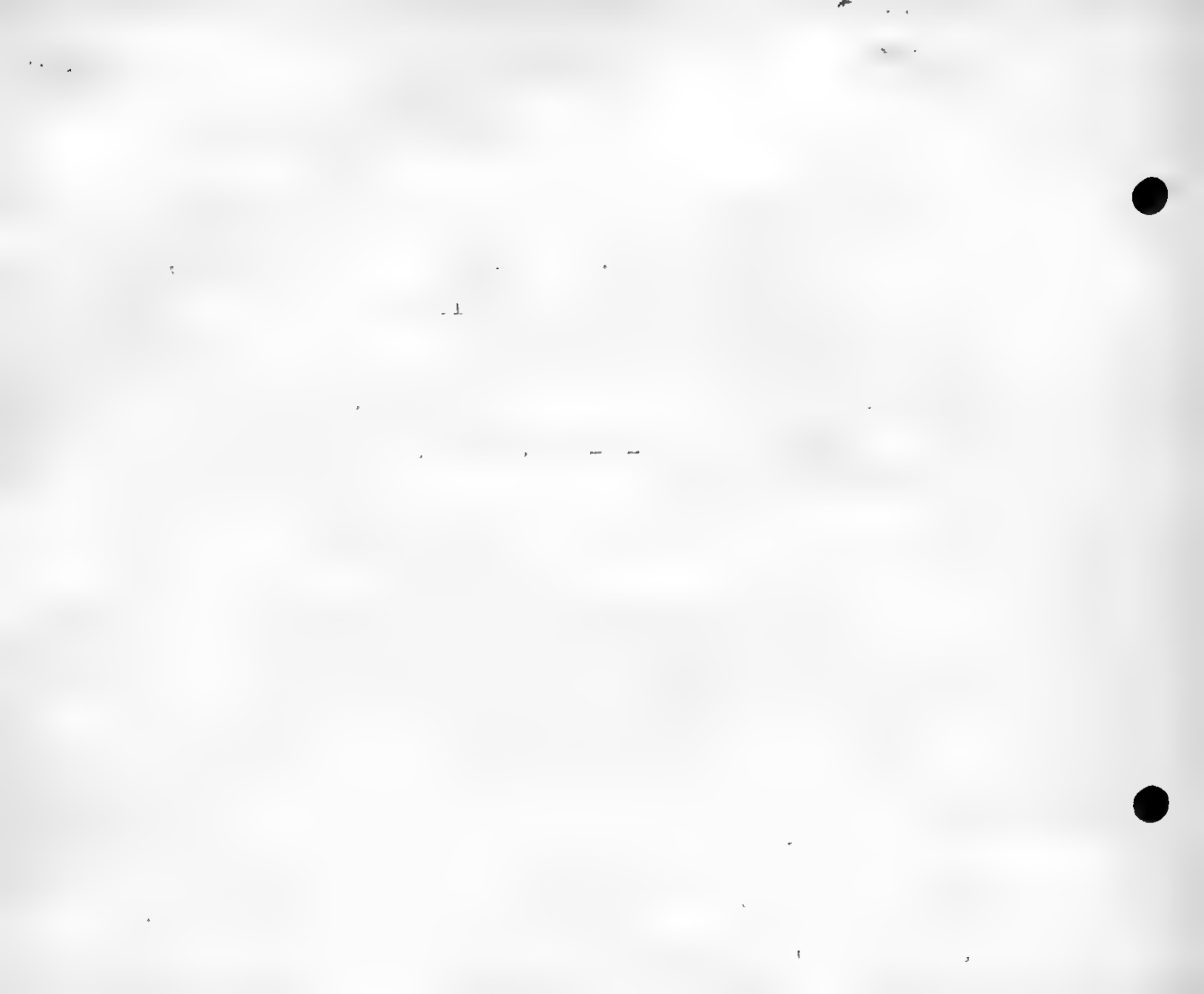
## CERTIFICATE OF DEATH

03870

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVY CHASE</b> c. LENGTH OF STAY IN 1b <b>6700 BROOKVILLE ROAD</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVY CHASE</b> d. STREET ADDRESS <b>6700 BROOKVILLE ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>RICHARD W. LINDSAY</b>		4 DATE OF DEATH Month Day Year <b>MARCH 12, 19 67</b>	
5. SEX <b>MALE</b>	6 COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>9/11/08</b>
9 AGE (In years last birthday) yrs <b>58</b>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INVESTIGATOR</b>	
10b KIND OF BUSINESS OR INDUSTRY <b>U. S. GOVERNMENT</b>		11. BIRTHPLACE (County & State, or foreign country) <b>OHIO</b>	
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>WALTER N. LINDSAY</b>	
14. MOTHER'S MAIDEN NAME <b>ISABEL V. DICKSON</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWII</b>	
16. SOCIAL SECURITY NO. <b>270-12-4633</b>		17. INFORMANT Address <b>JANICE M. LINDSAY, WIFE SAME AS #2 ABOVE</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis Generalized</b> DUE TO (b) <b>Carcinoma Pancreas</b> DUE TO (c) <b>3 Months</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 Months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f ((City or town) (County) (State))
21 I certify that (I) (this hospital) attended the deceased from <b>Feb-10, 1967</b> , to <b>3-12, 1967</b> , that (I) (we) last saw the deceased alive on <b>3-11, 1967</b> , and that death occurred at <b>4:54 AM</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>P.P. Andrews</b>		22b. DATE SIGNED <b>3-12-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>P.P. ANDREWS M.D.</b>		22d ADDRESS <b>Washington D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3/14/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>ROCKVILLE, MD.</b>
24. FUNERAL DIRECTOR <b>JOSEPH GAWLER'S SONS, INC., WASHINGTON, D.C.</b>		25. REGISTRATION DATE <b>MAR 14 1967</b> BY REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2c & d Film #3307 4/7/67 pg

03872

CERTIFICATE OF DEATH

03871

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLT CROSS HOSPITAL</u>				d. STREET ADDRESS <u>8311 Navaho Dr. Silver Spring, Md.</u>			
3 NAME OF DECEASED (Type or print) <u>FANNIE H. LITTMAN</u>				4 DATE OF DEATH <u>3</u> Month <u>31</u> Day <u>19</u> Year <u>67</u>			
5 SEX <u>FEMALE</u>		6 COLOR OR RACE <u>CAUC</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>7/4/89</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY		9 AGE (In years not birthday) <u>77</u> yrs.	
11. BIRTHPLACE (County & State, or foreign country) <u>WASH. D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Nathan Horn</u>				14. MOTHER'S MAIDEN NAME <u>Betsy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT Address <u>Ch.Ch., Md. Bernard Littman, 3124 Brooklawn Terr.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia (clinical)</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic heart disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Renal cell carcinoma right kidney</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>66</u> to <u>March 31</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>March 31</u> , 19 <u>67</u> , and that death occurred at <u>12:01 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/31/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. EIG</u>				22d. ADDRESS <u>6411 Colomille Rd Silver Spring, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/2/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Adas Israel</u>		23d. LOCATION (City or Town) (County) (State) <u>Wash., D.C.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>3501-14th St., NW, Wash. DC</u>				25a. RECD BY REGISTRAR DATE <u>APR 4 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	





FOR STATE  
HEALTH DEPT.

03873

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03872

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If July delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY 'IN 1b		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>9039 SLIGO CR. PKW.</u> e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3 NAME OF DECEASED (Type or print) <u>HAROLD CARL LOHREN</u>		4 DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3-14-08</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. GOVT-SEC</u>		10b KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>	9 AGE (In years last birthday) <u>59</u> yrs
11 BIRTHPLACE (State or foreign country) <u>PHILA. PA</u>		2 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>FREDERICK LOHREN</u>		14 MOTHER'S MAIDEN NAME <u>ANNA LOHREN</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>- -</u>	
17 INFORMANT Address <u>Mrs. B.A. Lohren (Wife) Same as # 1</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> DUE TO (b) <u>Coronary artery heart disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			19 WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u>		22. DATE SIGNED <u>3/16/1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		DEPUTY MEDICAL EXAMINER <u>Charles Judge</u>	
23a BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>	23b DATE THEREOF <u>3-17-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d LOCATION (City or Town) (County) (State) <u>Suitland, P.G., Md.</u>
24 FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a SIGNED BY REGISTRAR <u>20 1967</u>	



03874

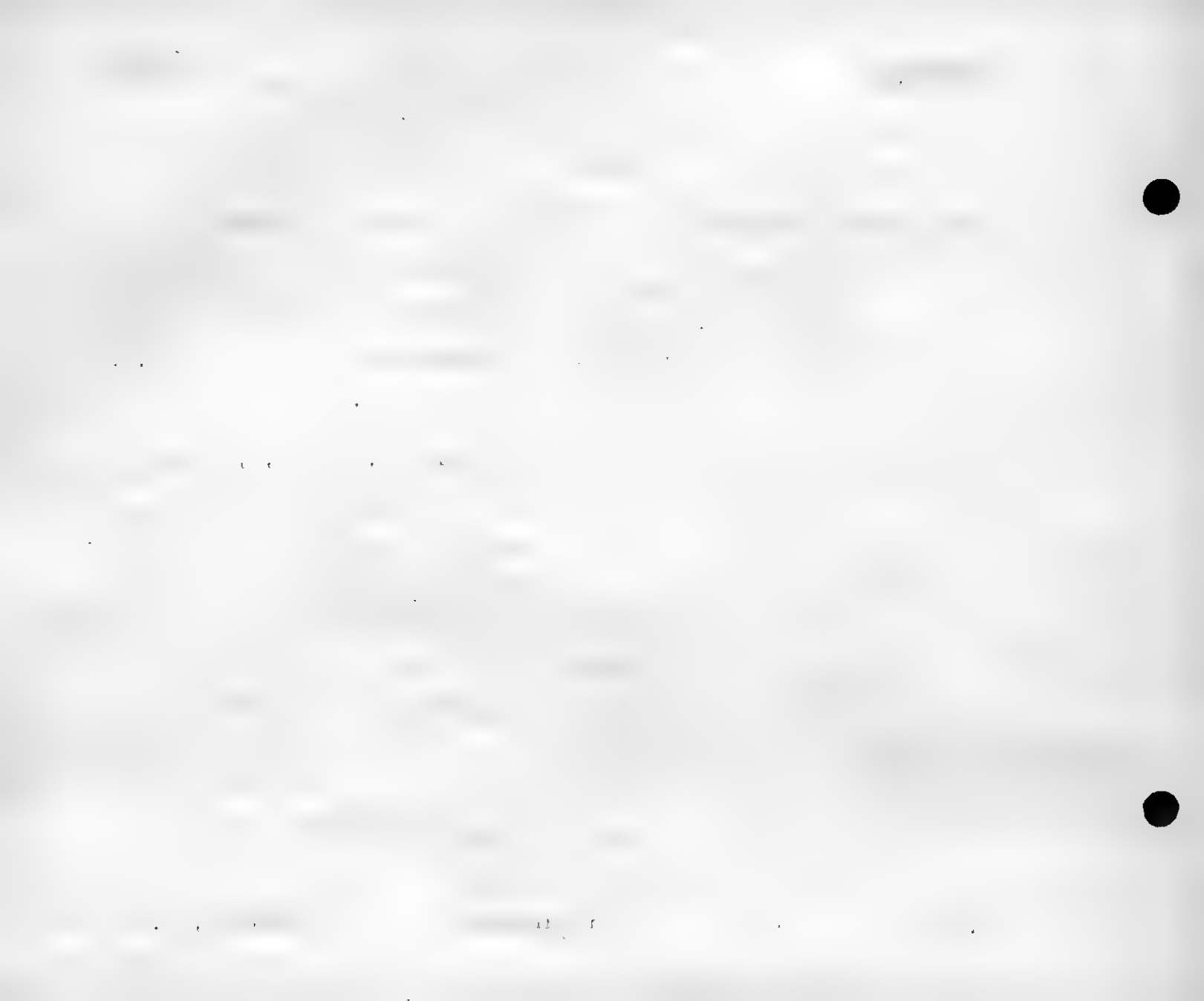
## CERTIFICATE OF DEATH

03873

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOLY CROSS HOSPITAL, SILVER SPRING</b>	
d. STREET ADDRESS <b>609 BROMLEY STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>GEORGE V. LUCKYJ</b>		4 DATE OF DEATH Month <b>3</b> Day <b>26</b> Year <b>1967</b>	
5 SEX <b>m</b>	6 COLOR OR RACE <b>w</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>2/28/27</b>
9 AGE (In years last birthday) <b>40 yrs</b>		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Navy Department</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Government</b>	
11 BIRTHPLACE (County & State or foreign country) <b>POLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Vasyl Luckyj</b>		14 MOTHER'S MAIDEN NAME <b>Marie Borovicka</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>571-44-4736</b>	
17. INFORMANT <b>Zenia Luckyj,</b>		Address <b>2 a, b, c, d above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial arrest</b> DUE TO (b) <b>Extensive myocardial infarct</b> DUE TO (c) <b>Coronary artery occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>3/23</b> , 19 <b>67</b> , to <b>3/24</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3/24</b> , 19 <b>67</b> , and that death occurred at <b>10:15 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Richard P. Delaney</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>RICHARD P. DELANEY</b>		22d. ADDRESS <b>4323 - HAYRD - SIL SPR. MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>30 MAR 67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>
24 FUNERAL DIRECTOR <b>Charles J. Francis</b>		25a REC'D BY REGISTRAR <b>Charles Judge</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>MAR 29 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-21 Fill in 3.8 MARYLAND-STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03875 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03874

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN b. <b>5 months</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>10210 Capitol View Avenue</b>				2. USUAL RESIDENCE (Where deceased lived, if last full time residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>10210 Capitol View Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Melanie</b>		First <b>Melanie</b> Middle <b>(nni)</b> Last <b>Lund</b>		4. DATE OF DEATH Month <b>March</b> Day <b>21</b> Year <b>19 67</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>October 5, 1966</b>		9. AGE (In years last birthday) yrs. <b>3</b> Months <b>7</b> Days <b>16</b>		10. IF UNDER 1 YEAR <b>3</b> Months <b>7</b> Days <b>16</b> IF UNDER 24 HRS. Hours <b>16</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Jeffrey B. Lund</b>		14. MOTHER'S MAIDEN NAME <b>Melinda Middleton</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Jeffrey B. Lund</b> Address <b>10210 Capitol View Avenue Silver Spring, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Viral pneumonitis accompanied by asphyxia</b> DUE TO (b) <b>due to aspiration of gastric contents</b> DUE TO (c) <b>due to aspiration of gastric contents</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased in-ant vomited and aspirated gastric contents</b>					
20c. TIME OF INJURY Hour a.m. <b>3:00 PM</b> Month, Day, Year <b>3-21 19 67</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>			
20f. (City or town) <b>Silver Spring</b> (County) <b>Montg.</b> (State) <b>Md.</b>							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Belden R. Read</b>		M.D. <b>BELDEN R. READ, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BELDEN R. READ, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>3/22/1967</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 23, 1967</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>			
22d. LOCATION (City, town, or country) <b>Prince Georges Co., Maryland</b>							
23. FUNERAL DIRECTOR <b>Glen Carter</b> <b>Warner E. Humphrey, Inc.</b>		ADDRESS <b>8434 Georgia Avenue Silver Spring, Md.</b>		DATE <b>APR 27 1967</b>			
24. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

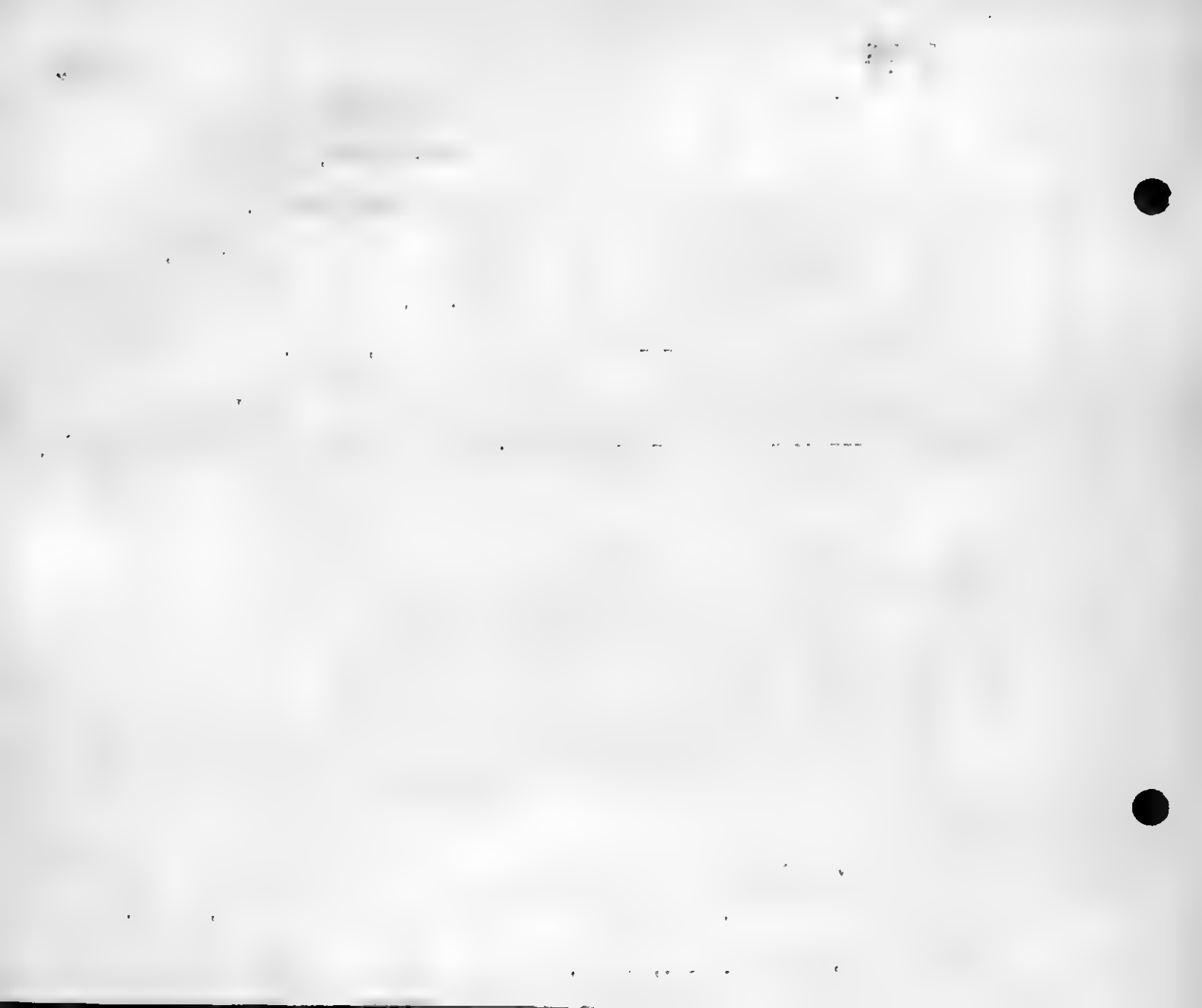


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if cremation, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
03876					03875							
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
a. COUNTY <b>MONTGOMERY</b>					a. STATE <b>New Jersey</b> b. COUNTY <b>Montgomery</b> ✓							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
<b>RFD Silver Spring</b>					<b>Silver Spring, Basking Ridge</b>							
c. LENGTH OF STAY IN ID					d. STREET ADDRESS							
					<b>49 Lyons Rd</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					e. IS RESIDENCE ON A FARM?							
<b>Lepard Nursing Home</b>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH			
			<b>Luella</b>		<b>R.</b>		<b>Lytle</b>		<b>March 22</b>			
5. SEX			6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DAY OF BIRTH		9. AGE (In years last birthday)			
<b>Female</b>			<b>Cauc</b>		<b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>Sept. 17, 1885</b>		<b>81</b> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?			
<b>Household</b>			<b>- - -</b>			<b>Grove City, Penna.</b>			<b>USA</b>			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME							
<b>Charles Ruffing</b>					<b>Katherine Young, same as #2</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT			Address		
<b>no</b>					<b>150-36-0573</b>		<b>Mrs. Katherine Sharp</b>			<b>2008 Forest Dale Dr. Silver Spring, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>										<b>10 years</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m. <b>19</b>					While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 27, 1962</b> , to <b>March 22, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan 30, 1962</b> , and that death occurred at <b>6:45 p.m.</b> from the causes and on the date stated above.												
22a. SIGNATURE					22b. DATE SIGNED							
<b>Burton A. Johnson</b>					<b>March 22, 1962</b>							
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS							
<b>BURTON A. Johnson, M.D.</b>					<b>11358 Cherry Hill Rd, Beltsville, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)				
<b>BURIAL</b>			<b>March 25, 1962</b>		<b>Oak Hill Cemetery</b>			<b>Sanky Lake, Penna.</b>				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE		
<b>Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland</b>					<b>MAR 27 1967</b>					<b>J. Charles Judge</b>		

MEDICAL CERTIFICATION





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03877

## CERTIFICATE OF DEATH

03876

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		2 USUAL RESIDENCE (Where deceased lived, if institution on residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Bal Harbour</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Randolph Nursing Home</b>		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) <b>Adele Treger</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>12</b> Year <b>1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>Sept. 25, 1902</b>
9 AGE (In years last birthday) yrs <b>64</b>		10 IF UNDER 1 YEAR Months <b>12</b> Days <b>19</b> Hours <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Treger</b>		14 MOTHER'S MAIDEN NAME <b>Annie Gordon</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b>578 18 9173</b>	
17 INFORMANT <b>Brother</b>		<b>4819 Poik Avenue</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <b>4200</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Bronchial asthma</b>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1958</b> , 19____, to <b>March 12, 1967</b> , that (I) (we) last saw the deceased alive on <b>MARCH 8, 1967</b> , and that death occurred at <b>1:40 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Weslym Oler</b>		22b. DATE SIGNED <b>MARCH 12 '67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Weslym Oler MD</b>		22d ADDRESS <b>4011 Randolph Rd., Wheaton, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>3-14-67</b>	23c NAME OF CEMETERY OR CREMATORY <b>B'nai Israel Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Oxon Hill, Maryland</b>
24 FUNERAL DIRECTOR <b>Bernard Danzansky &amp; Sons Washington DC</b>		25 REC'D BY REGISTRAR <b>MAR 15 1967</b>	
26 REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03878

CERTIFICATE OF DEATH

03877

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>	
c. LENGTH OF STAY IN 1b <b>11 Months</b>		d. STREET ADDRESS <b>2405 Arcola Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Randolph Hills Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lillie</b> Middle <b>May</b> Last <b>Mancini</b>		4. DATE OF DEATH <b>March 24 1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>Can</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/2/1896</b>
9. AGE (In years last birthday) <b>70 yrs</b>		10. IF UNDER 1 YEAR: Months <b>24</b> Days <b>24</b> Hours <b>19</b> Min <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Chevy Chase, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles Pugh</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Clark Phillips Pugh</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>219-54-7880</b>	
17. INFORMANT <b>Mrs. Robert Mancini</b>		Address <b>9610 Bristol Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral thrombosis</b> DUE TO <b>352X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 1966</b> to <b>3/24 1967</b> that (I) (we) last saw the deceased alive on <b>3/24 1967</b> , and that death occurred at <b>1142 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>A. F. Thibadeau</b>		22b. DATE SIGNED <b>3/24/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. F. THIBADEAU</b>		22d. ADDRESS <b>10111 Colesville Rd. Silver Spring, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-28-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Prince George County, Md.</b>
24. FUNERAL DIRECTOR <b>Robert A. Pugh</b>		25a. REC'D BY REGISTRAR <b>DATE 30 1967</b>	
ADDRESS <b>Bethesda, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03879

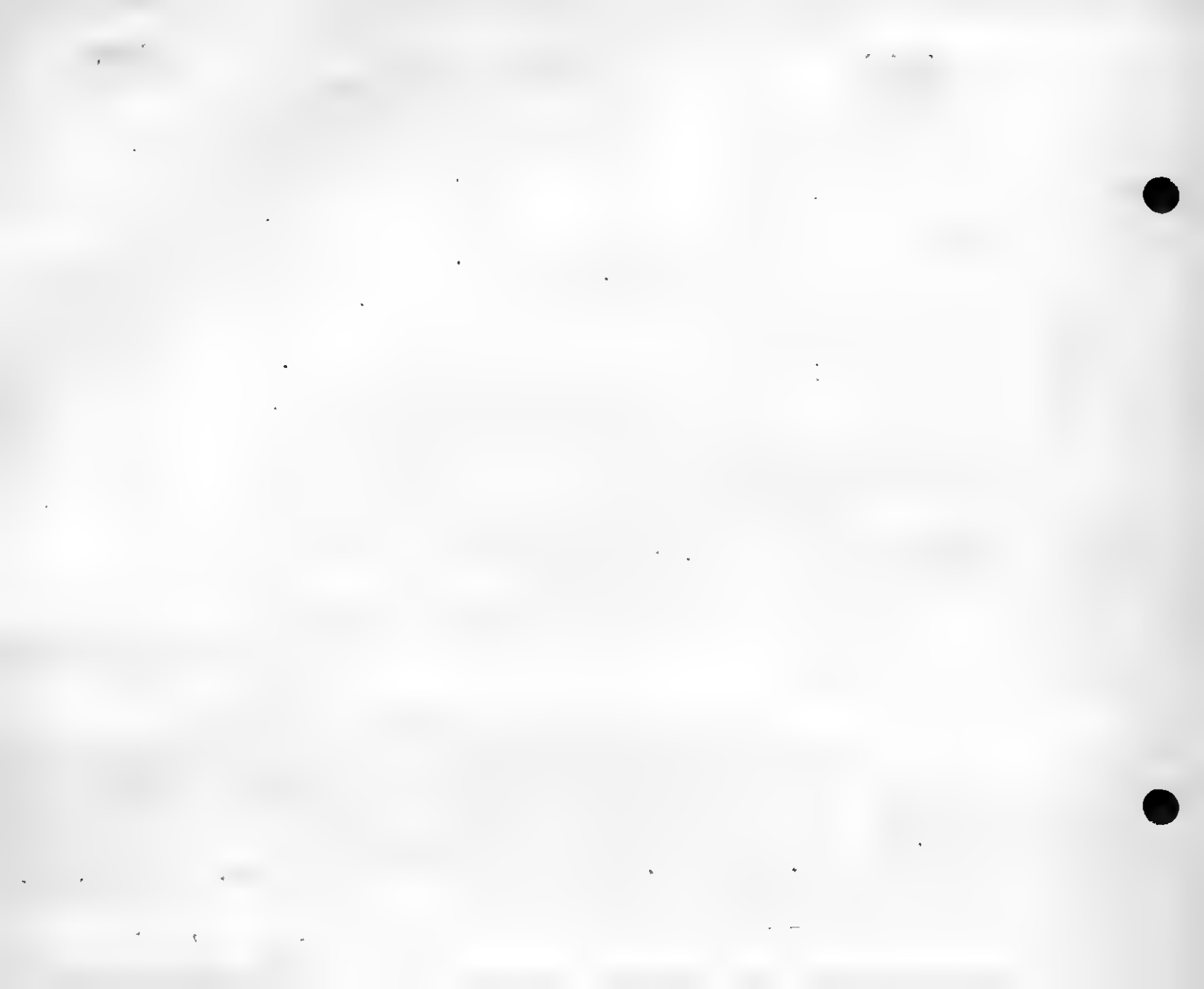
## CERTIFICATE OF DEATH

03878

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>17 days</u>		d. STREET ADDRESS <u>4890 Battery Lane, 322</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Francis Iola Marie</u>		4. DATE OF DEATH <u>March 29 1967</u>	
5 SEX <u>female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5-25-10</u>
9 AGE (In years last birthday) <u>56</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Washington - DC</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>Mr. John V. Casey Mason</u>	
14 MOTHER'S M maiden NAME <u>Miss Ann L. Lenderson</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16 SOCIAL SECURITY NO <u>579-38-7083</u>		17 INFORMANT <u>Mr. Adolph Marie - above</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>TERMINAL BRONCHOPNEUMONIA</u> DUE TO (b) <u>METASTATIC UNDIFFERENTIATED</u> DUE TO (c) <u>CARCINOMA OF THYROID</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 7, 1949</u> , to <u>MAR. 29, 1967</u> , that (I) (we) last saw the deceased alive on <u>MAR. 29, 1967</u> , and that death occurred at <u>7 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert G. Angle</u>		22b. DATE SIGNED <u>MAR. 29, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Robert G. Angle</u>		22d. ADDRESS <u>5009 Del Ray Ave. Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>4-1-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Md.</u>
24 FUNERAL DIRECTOR <u>Joseph Pauline Lowe</u>		25a. REC'D BY REGISTRAR <u>APR 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



03880

## CERTIFICATE OF DEATH

03879

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington San &amp; Hospital</b>		d. STREET ADDRESS <b>16301 Old Orchard Road</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Lyon</b> Last <b>Marletta</b>		4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 8, 1967</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Montgomery Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph John Marletta</b>		14. MOTHER'S MAIDEN NAME <b>Beverly Ann Slocum</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Joseph Marletta</b>		Address <b>16301 Old Orchard Rd. S.S.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>77350 Prematurity and Hyaline membrane Disease of Newborn</b> DUE TO (b) DUE TO (c)			INTERVA. BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE-CONDITION GIVEN IN PART I (a) <b>Hyaline membrane Disease</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/8</b> , 19 <b>67</b> , to <b>3/8</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3/8</b> , 19 <b>67</b> , and that death occurred at <b>3:45 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>H. H. Diamond</b>		22b. DATE SIGNED <b>3/8/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. H. DIAMOND</b>		22d. ADDRESS <b>911-SILVER SPRING AVE S.S. MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>March 11, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Maryland</b>
24. FUNERAL DIRECTOR <b>John B. Thomas &amp; Son, Inc.</b>		25a. REC'D BY REGISTRAR <b>MAR 13 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





03881

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04013

FOR STATE  
HEALTH DEPT.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>Hyattsville (LEWISDALE)</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash Saint Hospital</i>		d. STREET ADDRESS <i>2104 Banning Place</i>	
3 NAME OF DECEASED (Type or print) <i>Evelyn G. Martin</i>		4 DATE OF DEATH Month <i>3</i> Day <i>20</i> Year <i>1966</i>	
5 SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>Aug 29 - 1898</i>
10a. USUAL OCCUPATION (Give kind of work done during major part of life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>	9. AGE (In years last birthday) yrs <i>67</i>
11. BIRTHPLACE (State or foreign country) <i>Illinois</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>August B. Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Julia Waldin</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO <i>NONE</i>	
17. INFORMANT <i>GEORGE F. MARTIN</i>		Address <i>SAME AS #2</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Aspiration of Vomitus due to Toxic State</i> DUE TO (b) <i>Broncho-Pneumonia</i> DUE TO (c) <i>Diabetes Mellitus</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS A JIOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>In Toxic State - Vomited &amp; aspirated food</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>12:00</i> pm <i>3:20</i> 1966	20d. INJURY OCCURRED Where <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not White <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State) <i>Hyattsville Prince George's Md</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John B. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>3/20/66</i>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>3/24/66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>CEDAR HILL</i>	23d. LOCATION (City or town) (County) (State) <i>SUITLAND MD.</i>
24. FUNERAL DIRECTOR <i>W. W. CHAMBERS CO.</i>		25a. REC'D BY REGISTRAR <i>SILVER SPRING</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

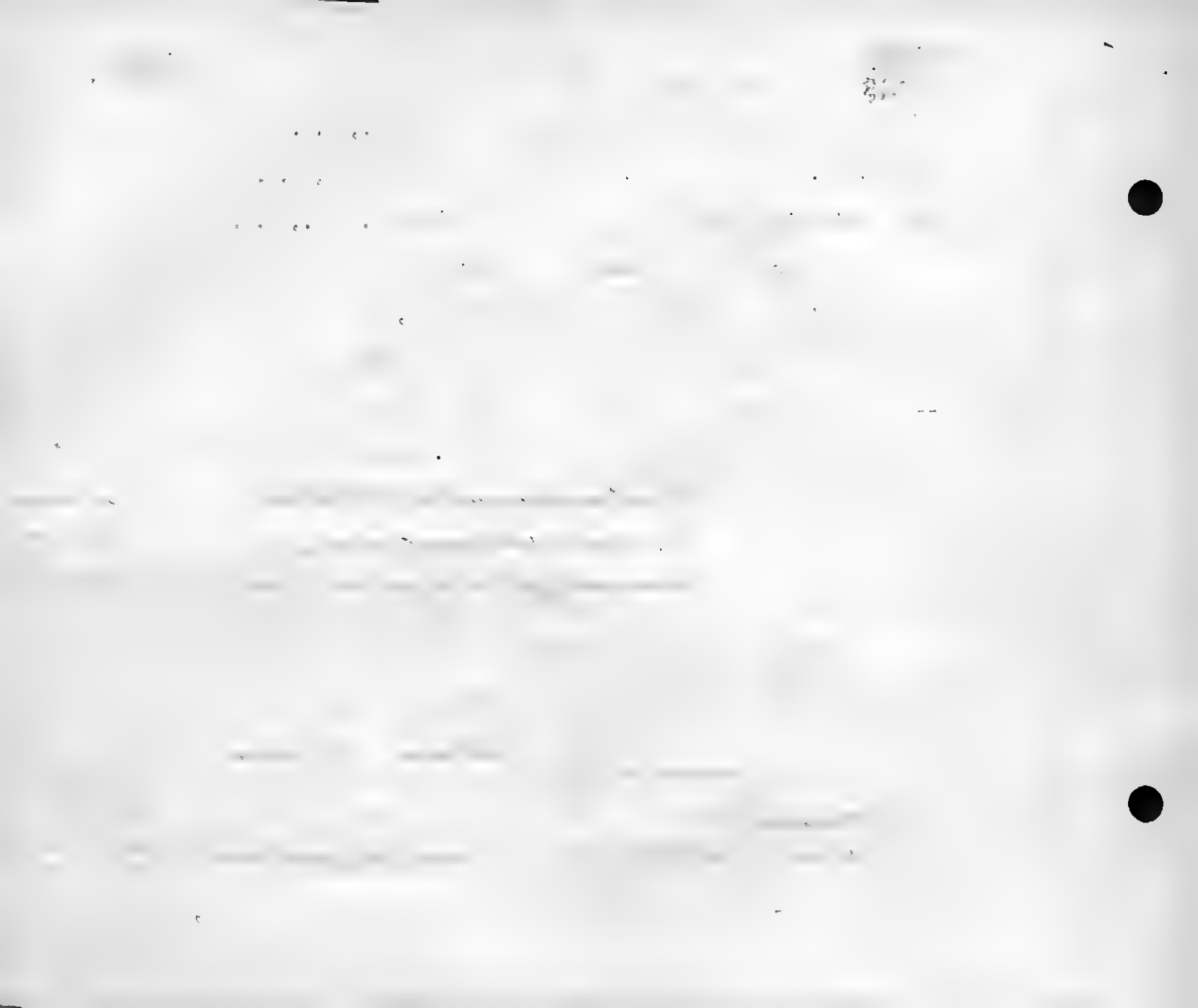
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03882

CERTIFICATE OF DEATH

03880

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA, MD.</b> c. LENGTH OF STAY IN TB <b>17 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Resmor Sanitarium &amp; Hospital</b>		2. USUAL RESIDENCE (Where deceased lived if in hospital; Residence before admission) a. STATE <b>Wash., D.C.</b> b. COUNTY <b>Washington, D.C.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> d. STREET ADDRESS <b>6008 Mass. Ave., N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Luddy</b> First Middle Last 4. DATE OF DEATH <b>March 6 19 67</b> Month Day Year		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>April 15, 1878</b> 9. AGE (In years lost birthday) <b>88 yrs</b> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 11. BIRTHPLACE (County & State or foreign country) <b>Idaho</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Henderson</b> 14. MOTHER'S MAIDEN NAME <b>Morton</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b> 16. SOCIAL SECURITY NO. <b>—</b> 17. INFORMANT <b>Son John C. Martin</b> Address <b>Same as Item 2.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>331X Cerebrovascular accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Cerebral arteriosclerosis</b> (c) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>3 hrs.</b> <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour "a.m." p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>February 19 67</b> to <b>March 6, 19 67</b> , that (I) (we) lost the deceased alive on <b>March 4 19 67</b> , and that death occurred at <b>2:31 P.M.</b> from causes and on the date stated above 22a. SIGNATURE <b>Ronald W. Barr</b> 22b. DATE SIGNED <b>3-6-67</b> 22c. PHYSICIAN'S NAME (Type) <b>RONALD W. BARR, MD</b> 22d. ADDRESS <b>1044 OLD GEORGETOWN RD BETHESDA, MD</b> 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		23a. BURIAL, CREMATION, REMOVA (Specify) <b>Cremation</b> 23b. DATE THEREOF <b>3-7-67</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b> 23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b> 24. FUNERAL DIRECTOR <b>Robert C. Humphrey</b> 25a. REC'D BY REGISTRAR <b>MAR 10 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles J. Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03883

CERTIFICATE OF DEATH

03881

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <del>XXXXXXXXXXXX</del> <u>Kensington</u> d. STREET ADDRESS <u>10613 Concord Street</u> <del>XXXXXX XXXXXX Road</del> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. William Fletchal Matthews</u>		4. DATE OF DEATH Month Day Year <u>March 11 19 67</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-26-68</u>
9. AGE (In years last birthday) <u>98</u> yes		10. IF UNDER 1 YEAR Months Days Hours Min <u>19 67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>B &amp; O Railroad Station Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>William Matthews</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Matthews</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO <u>709-078493</u>	
17. INFORMANT <u>Russell Matthews</u> <del>XXXXXXXXXXXX</del>		Address <u>8803 Riggs Road Adelphi, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>Congestive heart failure</u> DUE TO (c) <u>Anemia, hypochromic severe</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 days</u> <u>1-2 days</u> <u>3-4 mo</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>old age (98 yrs old) Enlarged liver &amp; jaundice.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>6-9</u> , 19 <u>66</u> , to <u>3-11</u> , 19 <u>67</u> , that (1) we last saw the deceased alive on <u>3-10</u> , 19 <u>67</u> , and that death occurred at <u>6:25</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John R. Spencer</u>		22b. DATE SIGNED <u>3-11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John R. Spencer</u>		22d. ADDRESS <u>BURTONSVILLE, MD</u>	
23a. BURIAL, CREMATON, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Mar 14, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Baptist Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Cedar Grove, Maryland</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>15 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03884

CERTIFICATE OF DEATH

03882

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>Virginia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb <b>12 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lovettsville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				d. STREET ADDRESS <b>Route 2, Box 111</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>C.</b> Last <b>MCCALL</b>				4 DATE OF DEATH Month <b>March</b> Day <b>29</b> Year <b>19 67</b>			
5 SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Dec. 30, 1914</b>		9. AGE (in years last birthday) <b>52</b> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Ridgewood, New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alfred Post Coburn</b>				14. MOTHER'S MAIDEN NAME <b>Florence Woodward</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>231 66 6680</b>		17. INFORMANT <b>Lovettsville</b> Address <b>Va.</b> <b>Charles E. McCall, Route 2, Box 111</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hemorrhagic Infraction of the Bowel</b> DUE TO <b>Anemia Severe</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO <b>Secondary to Leukemia</b> (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Mar. 17</b> , 19 <b>67</b> , to <b>Mar. 29</b> , 19 <b>67</b> that (he)(we) last saw the deceased alive on <b>Mar. 29</b> , 19 <b>67</b> , and that death occurred at <b>1150 M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>R. J. Kinney MD</b>				22b. DATE SIGNED <b>Mar. 30, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>R. J. Kinney MD</b>	
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>New York N.Y.</b>	
24. FUNERAL DIRECTOR <b>Muse &amp; Reed, Inc.</b> <b>101 Edwards Ferry Road, Leesburg, Virginia</b>				25a. REC'D BY REGISTRAR <b>APR 3 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03885

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03883

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Bucklin</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>1 Day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>RFD #2 Box 8</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>Paul L. McCarty</b>		4 DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Cauc</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Jan. 7, 1946</b>
9 AGE (in years last birthday) <b>21 yrs</b>		10 F UNDER 1 YEAR IF UNDER 24 HRS Months <b>21</b> Days <b>21</b> Hours <b>21</b> Min <b>21</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USA</b>		10b KIND OF BUSINESS OR INDUSTRY <b>US MARINES</b>	
11 BIRTHPLACE (State or foreign country) <b>Missouri</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Barry R. McCarty</b>		14 MOTHER'S MAIDEN NAME <b>UNK</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16 SOCIAL SECURITY NO <b>494-48-9870</b>	
17 INFORMANT <b>Navy records</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Multiple Injuries Sereve</b> DUE TO (b) <b>Trauma From Auto Accident</b> DUE TO (c) <b>164</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH. <b>24 hr.</b>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Lost control of car and crashed into another car</b>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>10:00 m</b> Mar. 23 19 67		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> <b>WEEK Street</b>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Alexander</b>		20f. (City or town) (County) (State) <b>Va.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John G. Ball</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John G. Ball MD, Deputy</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>3/28/67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>PLEASANT GROVE</b>		23d LOCATION (City or Town) (County) (State) <b>Bucklin, Missouri</b>	
24 FUNERAL DIRECTOR <b>W. W. Chambers Co.</b>		25a REC'D BY REGISTRAR <b>29 1967</b>	
ADDRESS <b>1400 Chapin St., N.W. Washington, D. C.</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

22. DATE SIGNED  
**3/26/67**



03886

## CERTIFICATE OF DEATH

-03884

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>--</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>18 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Danville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>				d. STREET ADDRESS <b>1217 Glen Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>Augusta</b> Last <b>McClelland</b>				4. DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8 August 1950</b>		9. AGE (In years last birthday) yrs. <b>16</b>		IF UNDER 1 YEAR Months <b>16</b> Days <b>16</b> Hours <b>16</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Philemon Augusta McClelland</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Irving</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hodgkin's Disease</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Jaundice of unknown etiology</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (A) (this hospital) attended the deceased from <b>8 March</b> , 19 <b>67</b> , to <b>26 March</b> , 19 <b>67</b> , that (A) (we) last saw the deceased alive on <b>26 March</b> , 19 <b>67</b> , and that death occurred at <b>3:40 M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Leroy Fass</b>				P.M. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>27 March 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Leroy Fass, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>3/28/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Danville, Virginia</b>	
24. FUNERAL DIRECTOR <b>Washington &amp; Shelley's</b>				ADDRESS <b>1727 N. Mount</b>		25a. REC'D BY REGISTRAR <b>DAT MAR 31 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03887 CERTIFICATE OF DEATH 03885											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FAIRLAND NRSNG HOME 2101 FAIRLAND RD</u>						d. STREET ADDRESS <u>1212 FAIRLAND ROAD</u>					
3. NAME OF DECEASED (Type or print) First <u>MINERVA</u> Middle <u>-</u> Last <u>McCulloch</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>7</u> Year <u>1967</u>			5. SEX <u>FEMALE</u>			6. COLOR OR RACE <u>WHITE</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>7-9-1874</u>			9. AGE (In years last birthday) <u>92</u> yrs.			10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>LEXINGTON KENTUCKY</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						13. FATHER'S NAME <u>FREDERICK GRISWOLD CLYCE</u>			14. MOTHER'S MAIDEN NAME <u>CLARK</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)						16. SOCIAL SECURITY NO. <u>219-54-8408-T</u>			17. INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> DUE TO (b) <u>Cerebro-vascular accident</u> DUE TO (c) <u>Cardiac ischemia</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>8 months</u> <u>2 1/2 yrs.</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1930</u> to <u>March 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 7, 1967</u> , and that death occurred at <u>140 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Katherine A. Chapman</u>						22b. DATE SIGNED <u>March 7, 1967</u>			22c. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (Type) <u>Katherine A. Chapman</u>						22e. ADDRESS <u>3924 Baltimore St, Kensington, Md. 20795</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <u>3/8/1967</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln</u>			23d. LOCATION (City, town or county) (State) <u>Bladensburg Maryland</u>		
24. FUNERAL DIRECTOR <u>John T. Waters</u>						25a. REC'D BY REGISTRAR <u>10 MAR 10 1967</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



03888

## CERTIFICATE OF DEATH

03886

1. PLACE OF DEATH a. COUNTY <u>montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u>		c. LENGTH OF STAY IN Tb <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Naval Hospital</u>				d. STREET ADDRESS <u>4633 South 4th Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Julia Jones MC ENTIRE</u>				4. DATE OF DEATH Month Day Year <u>March 2 19 67</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 22, 1914</u>	9. AGE (In years last birthday) yrs <u>52</u>	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Vandemere, N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>O'Connor Lee Jones</u>				14. MOTHER'S MAIDEN NAME <u>Susan Frances Linton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>231 07 1019</u>		17. INFORMANT <u>4th St. Arlington Va.</u> <u>Capt. Fred E. McEntire, Jr., 4633 South</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: <u>100 IMMEDIATE CAUSE (a) <del>Gastric ulcer with hemorrhage</del> Massive bilateral pulmonary atelectasis/</u> DUE TO <u>(b) Gastric ulcer with hemorrhage</u> DUE TO <u>(c)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Arteriosclerotic heart disease with cerebral encephalomalacia</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Feb. 28</u> , 19 <u>67</u> , to <u>March 2</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (I) (we) last saw the deceased alive on <u>March 2</u> , 19 <u>67</u> , and that death occurred at <u>730A M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>William R. Hix</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>3 March 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>William R. Hix</u>				22d. ADDRESS <u>Naval Hospital, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>Burial</u>	<u>March 6, 1967</u>	<u>Arlington National Cemetery, Arlington,</u>		<u>Va.</u>			
24. FUNERAL DIRECTOR <u>Arlington Funeral Home</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>3901 North Fairfax Dr. Arlington, Va.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





FOR STATE  
HEALTH DEPT.

03889

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03887

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>Wheaton</u>	
c LENGTH OF STAY IN 1b <u>9</u> months			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11506 Bucknell Dr apt#</u>		d STREET ADDRESS <u>11506 Bucknell Dr</u>	
e 5 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>MILDRED C. McFARLAND</u>		4 DATE OF DEATH Month <u>3</u> Day <u>29</u> Year <u>1967</u>	
5 SEX <u>W</u>	6 CO. OR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>June 19, 1905</u>
9 AGE (In years most birthday) <u>61</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11 BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12 CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13 FATHER'S NAME <u>Raymond B. Cobb</u>		14 MOTHER'S MAIDEN NAME <u>Unknown Cox</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16 SOCIAL SECURITY NO <u>No</u>	
17 INFORMANT <u>Elden McFarland</u>		Address <u>11506 Bucknell Drive Wheaton, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis due to</u> DUE TO (b) <u>Adenocarcinoma of cecum with metastasis</u> DUE TO (c) <u></u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o m p m <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>3/29/1967</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, City, Town, or County)			
23a BURIAL, CREMATION REMOVAL, SPECIAL	23b DATE THEREOF <u>April 3, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Highland Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Covington, Kentucky</u>
24 FUNERAL DIRECTOR <u>John B. Thomas, Warner E. Humphrey, Inc.</u>		25a REC'D BY REGISTRAR <u>APR 3 1967</u>	
Address <u>8434 Georgia Avenue Silver Spring, Md.</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03880

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03888

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if instit. on Res. before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
c. LENGTH OF STAY IN lb. <u>D.O.A.</u>		d. STREET ADDRESS <u>8026 - 14th ave apt 1</u>	
a. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San + Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Rosemary Zeis McKenney</u>		4 DATE OF DEATH Month <u>3</u> Day <u>10</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-2-14</u>
9 AGE (In years last birthday) <u>52</u> yrs.		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Wash, D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Edmund C. Zeis</u>		14. MOTHER'S MAIDEN NAME <u>Catherine O'Dwyer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Sameul McKenney</u>		Address <u>Same as # 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. <u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary Insufficiency - Acute</u> DUE TO (b) <u>Cardio Vascular Disease -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>3/10/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>3-13-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland Prince Geo Md</u>
24. FUNERAL DIRECTOR <u>Robert A. Mattingly</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
Address <u>131 11 S.W. Wash, D.C. 20003</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAR 13 1967</u>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03891

## CERTIFICATE OF DEATH

Reg. Dist. No. 03889

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10600 St. Paul Street</b>				d. STREET ADDRESS <b>10600 St. Paul Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>JANE</b> Middle <b>FOX</b> Last <b>McMAHON</b>				4. DATE OF DEATH Month <b>March</b> Day <b>12</b> Year <b>19 67</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 27, 1897</b>		9. AGE (In years last birthday) <b>69</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk - Railroad</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Montgomery Fox</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Taylor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Husband Joseph M. McMahon</b> Address <b>Same as Item 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CHRONIC DEBILITATION</b> DUE TO (c) <b>MALIGNANT BRAIN TUMOR</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 Hrs.</b> <b>8 Mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October, 1966</b> to <b>March 12, 1967</b> , that I last saw the deceased alive on <b>March 11, 1967</b> , and that death occurred at <b>7:40 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>11,000 Old Georgetown Road</b> DATE SIGNED <b>March 12, 1967</b>							
ACTUAL SIGNATURE <b>Robert T. Thibadeau</b>		PHYSICIAN'S NAME (Type) <b>Robert T. Thibadeau, M.D.</b> <b>Rockville, Maryland, 20852</b>					
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-15-67</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Andrews Chapel Cemetery, Vienna, Virginia</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>				24. REC'D BY REGISTRAR <b>16 1967</b>		24b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03892

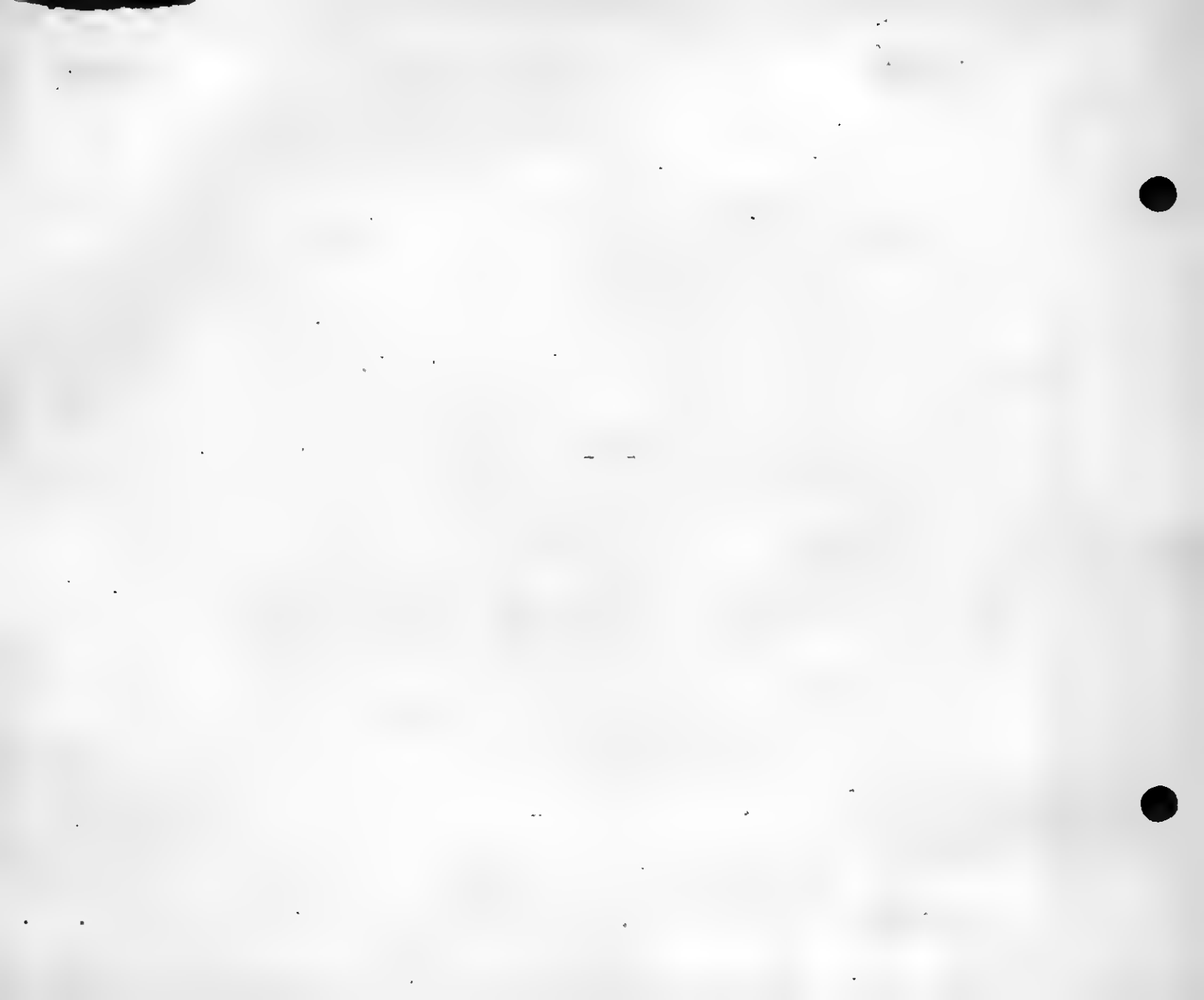
## CERTIFICATE OF DEATH

03890

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
c. LENGTH OF STAY IN 1b <u>6 Days</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		a. STREET ADDRESS <u>4220 EVERETT ST</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Norman SHERIDAN MEESE</u>		4 DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-5-18</u>
9 AGE (In years last birthday) <u>48</u> yrs		10 UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Relief-Economist - U.S. Govt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Jacob Meese</u>		14 MOTHER'S MAIDEN NAME <u>Anna Sayford</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes U.S. Army</u>		16. SOCIAL SECURITY NO <u>217-34-0683</u>	
17 INFORMANT <u>Norman Meese - Son - Same</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO (b) <u>Arteriosclerotic heart dis. acc.</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>10-14 days</u> <u>15 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/1</u> , 19 <u>55</u> to <u>3/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/27/67</u> , and that death occurred at <u>3:30 PM</u> , from causes and on the date stated above			
22a SIGNATURE <u>John E. Everett</u> M.D.		22b DATE SIGNED <u>3/28/67</u>	
22c PHYSICIAN'S NAME (Type) <u>JOHN E. EVERETT</u>		22d ADDRESS <u>94 Conn. Av. Kensington Md.</u>	
23a BURIAL, CREMATION, REMOVA, (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Cremation</u>	<u>3/31/67</u>	<u>Ft. Lincoln Crematory</u>	<u>Prince Georges Co. Md.</u>
24 FUNERAL DIRECTOR <u>W. H. Hine Co.</u>	25a. REC'D BY REGISTRAR <u>2801 14th St. Wash, D.C.</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03893

## CERTIFICATE OF DEATH

03891

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Greece</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN IS <b>19 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Almiro</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>		d. STREET ADDRESS <b>Vrynena, Magnesis</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>John (None) Melemes</b>		4 DATE OF DEATH Month Day Year <b>March 29 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8 June 1935</b>
9. AGE (In years last birthday) yrs. <b>31</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Greece</b>
12. CITIZEN OF WHAT COUNTRY? <b>Greece</b>		13. FATHER'S NAME <b>Christos Melemes</b>	
14. MOTHER'S MAIDEN NAME <b>Vasiliki Makri</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT Address <b>The Medical Record The Clinical Center, Bethesda, Maryland</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4211</b> DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>Ventricular Arrhythmias</b> DUE TO (c) <b>Calcific Aortic Stenosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>seconds</b> <b>2 1/2 hours</b> <b>11 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Open heart surgery precipitated death</b>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I (this hospital) attended the deceased from <b>10 March, 1967</b> , to <b>29 March, 1967</b> , that (X) (we) last saw the deceased alive on <b>29 March 1967</b> , and that death occurred at <b>5:15 M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <i>Lee Patrick Enright</i>		22b. DATE SIGNED <b>31 March 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lee Patrick Enright, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>4-5-67</b>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State) <b>Almiro, Greece</b>
24. FUNERAL DIRECTOR <b>Travis 389 Rt. 1 - Greenbelt, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 10 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>William S. Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2. 2.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if on-<sup>71</sup> sent, within 72 hours after death.

VR A15  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03894

CERTIFICATE OF DEATH

03892

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>12 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>313 University Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alice Eudora Mellinger</u>		4. DATE OF DEATH Month Day Year <u>4/6 March 1 19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-11-88</u>
9. AGE (in years last birthday) <u>78</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Charles Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Ella F. Glotfeldy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Patient's chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5702</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> (c) <u>Thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>24-30-66</u> , 19 <u>66</u> , to <u>12-11-67</u> , 19 <u>67</u> that (I) (we) lost the deceased alive on <u>2-28-67</u> and that death occurred at <u>1</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Morell C. Quinnas</u> M.D.		22b. DATE SIGNED <u>3/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MORELL C. QUINNAS</u>		22d. ADDRESS <u>Takoma Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Md.</u>
24. FUNERAL DIRECTOR <u>Charles E. Jones</u>		25a. REC'D BY REGISTRAR <u>Charles E. Jones</u> DATE <u>3/1/67</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles E. Jones</u>	

MAR 6 1967



03895

## CERTIFICATE OF DEATH

03895

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before burials, if any) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>		d. STREET ADDRESS <b>2801 East-West Highway</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Arthur L. Miller</b>		4. DATE OF DEATH Month Day Year <b>March 16 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-24-1892</b>
9. AGE (In years last birthday) <b>74 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>19 67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Physician</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Nebraska</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>R. J. Miller</b>		14. MOTHER'S MAIDEN NAME <b>- - - Louis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>- - - - -</b>	
17. INFORMANT <b>Margaret J. <del>XXXX</del> Miller,</b>		Address <b>See Item #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Congestive heart failure</b> DUE TO (b) <b>Ischemic heart disease</b> DUE TO (c) <b>Coronary Artery Disease (Arteriosclerosis)</b> INTERVAL BETWEEN ONSET AND DEATH <b>8 mo</b> <b>8 years</b> <b>8 yrs</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Arteriosclerosis obliterans; Arteriosclerotic cerebrovascular disease</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/22, 1959</b> to <b>3-16, 1967</b> that (I) (we) last saw the deceased alive on <b>Feb 23, 1967</b> , and that death occurred at <b>8:10 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Andrew G Prandoni</b>		22b. DATE SIGNED <b>3-16-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Andrew G Prandoni</b>		22d. ADDRESS <b>2520 L St NW Washington DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-20-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville, Md.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>		25a. REC'D BY REGISTRAR <b>Mar 20 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03896

CERTIFICATE OF DEATH

03894

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Wheaton</b> c. LENGTH OF STAY IN 1b <b>1 month</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>University Nursing Home</b>		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>8201 16th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Ethel (no middle name) Miller</b>		4 DATE OF DEATH Month Day Year <b>March 13 1967</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>6/1/1903</b>
9 AGE (In years last birthday) <b>63 yrs.</b>		10 UNDER 1 YEAR Months Days Hours Min. <b>19 67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady &amp; housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) <b>Balto., Md.</b>
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Nathan Fisman</b>	
14. MOTHER'S MAIDEN NAME <b>Bessie Levinson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Lewis Miller-807 Caddington Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary metastatic disease</b> DUE TO (b) <b>breast carcinoma of breast</b> DUE TO (c) <b>4 yrs.</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10 years ago</b> to <b>Mar 13, 1967</b> , that (I) (we) last saw the deceased alive on <b>Mar 13, 1967</b> , and that death occurred at <b>7:45 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Sydney Leventhal</b>		22b. DATE SIGNED <b>Mar 13, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Sydney Leventhal, M.D.</b>		22d. ADDRESS <b>9210 Colesville Rd., Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE THEREOF <b>3/13/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>--</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24 FUNERAL DIRECTOR <b>The S.H. Hines Company</b>		25a. REC'D BY REGISTRAR <b>MAR 14 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03897						03895					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <i>Montgomery</i>			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>			a. STATE <i>Maryland</i>			b. COUNTY <i>Montgomery</i>		
			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>3924 Decatur Avenue</i>						d. STREET ADDRESS <i>3924 Decatur Ave</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First <i>WILLIAM</i> Middle <i>DAVID</i> Last <i>MILLER</i>			4. DATE OF DEATH			Month <i>March</i> Day <i>17</i> Year <i>1967</i>		
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec. 29, 1912</i>		9. AGE (In years last birthday) <i>54</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bricklayer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>William David Miller Sr.</i>						14. MOTHER'S MATHEN NAME <i>Margaret Haller</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>214 03 8609</i>		17. INFORMANT Address <i>Mrs. Jeanne P. Miller (Same as #2)</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>coronary thrombosis</i>											
DUE TO (b) _____											
DUE TO (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral arteriosclerosis, generalized arteriosclerosis</i>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <i>2/18/67</i> , 19 <i>67</i> , to <i>3/17</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>3/17/67</i> , 19 <i>67</i> , and that death occurred at <i>10 P.M.</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Patrick Jameson</i>								22b. DATE SIGNED <i>3/18/67</i>			
22c. PHYSICIAN'S NAME (Type) <i>PATRICK JAMESON</i>								22d. ADDRESS <i>11718 Georgia Silver Spring Ave</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>March 21, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>George Washington</i>		23d. LOCATION (City, town or county) (State) <i>Adelphi, Prince Georges Co Md.</i>					
24. FUNERAL DIRECTOR <i>Arthur Walters, 254 Carroll St NW, D.C.</i>						25a. REC'D BY REGISTRAR <i>MAR 21 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



03898

CERTIFICATE OF DEATH

03896

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY <u>MONTGOMERY</u> MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>3 mo. 20 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING, MD.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross of Silver Spring</u>				d. STREET ADDRESS <u>11503 NAIRN Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HARRY MOORE</u>				4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/15/03</u>	9. AGE (In years last birthday) <u>63</u> yrs	10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.		11. IF UNDER 24 HRS. Hours <u>0</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>William P. Moore</u>				14. MOTHER'S MAIDEN NAME <u>Cecelia Dorsey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>290-22-5999</u>		17. INFORMANT <u>Mrs. Vincent Oliverio</u> Address <u>11503 Nairn Road Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Coronary artery disease</u> DUE TO (c) <u>last</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>by heart</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 16</u> , 19 <u>67</u> to <u>March 16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 16</u> , 19 <u>67</u> , and that death occurred at <u>5:27 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>March 16, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. EIG</u>	
22d. ADDRESS <u>1641 Columbia Rd Silver Spring, Md.</u>							
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Trans-burial</u>		23b. DATE THEREOF <u>March 20, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Cincinnati, Ohio</u>	
24. FUNERAL DIRECTOR <u>C. Glen Carter Co., Inc. 18434 Georgia Avenue</u> <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>MAR 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

M.D. & D. FILM 3-10-67											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
038997											
Items #14 & 15 Film #C-300 3/10/67 DC											
03897											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>KEESINGTON</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>KANSINGTON</u>					
c. LENGTH OF STAY IN 1b <u>—</u>						d. STREET ADDRESS <u>5118 Westridge Rd., N. W.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARROLL HALL SANITARIUM</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>P</u> Last <u>Mott</u>						4. DATE OF DEATH Month <u>MARCH</u> Day <u>8</u> Year <u>1967</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-2-1886</u>		9. AGE (In years last birthday) <u>80</u> yrs. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>				11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>RICHARD R. PITT</u>						14. MOTHER'S MAIDEN NAME <u>ALINE DIXON Wickhouse</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>231-10-8828</u>		17. INFORMANT Address <u>WASHINGTON, DC</u> <u>RICHARD A. MOTT - 5118 WESTRIDGE RD</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atrial Fibrillation with heart failure</u>										<u>36 hours</u>	
DUE TO (b) <u>CORONARY ARTERIOSCLEROTIC HEART DISEASE</u>										<u>1 year</u>	
DUE TO (c) <u>ARTERIOSCLEROSIS, GENERAL SOLID</u>										<u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 15, 1966</u> , to <u>March 8, 1967</u> , that (I) (two) last saw the deceased alive on <u>March 8, 1967</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Frank S. Bacon</u>						22b. DATE SIGNED <u>MARCH 8, 1967</u>					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS <u>2141 - K-Street N.W.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				23b. DATE THEREOF <u>3-10-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Norfolk, Va.</u>			
24. FUNERAL DIRECTOR <u>Joseph Hawley Sons</u>						25a. REC'D BY REGISTRAR <u>Wash., D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 13 1967</u>	

MEDICAL CERTIFICATION



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03900

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03898

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>D.C.</u> b COUNTY <u>✓</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c LENGTH OF STAY IN 1b <u>35 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>		e STREET ADDRESS <u>1612 Mass. Ave. SE</u>	
3. NAME OF DECEASED (Type or print) First <u>Owen</u> Middle <u>Fisher</u> Last <u>Mullen</u>		4 DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 17, 1876</u>
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Government</u>		9b AGE (In years last birthday) <u>90</u> yrs	
10b KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11 BIRTHPLACE (State or foreign country) <u>Penn. a.</u>	
13 FATHER'S NAME <u>Owen, Edward Mullen</u>		14 MOTHER'S MAIDEN NAME <u>Caroline Fisher</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>✓</u>		16 SOCIAL SECURITY NO. <u>2712 Emmett Road</u>	
17 INFORMANT <u>Walter W. Mullen Sil Spg., Md.</u>		18 ADDRESS <u>2712 Emmett Road</u>	
8 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 9040 IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> DUE TO (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Fracture - Hip</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 days</u> <u>59 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fall at home causing fracture of Hip</u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>1</u> 8 <u>1967</u> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f (City or town) (County) (State) <u>Washington D.C.</u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u>		22. DATE SIGNED <u>3/6/67</u>	
EXAMINER'S NAME (Type) <u>John B. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>3/6/67</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>March 9, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem.</u>	23d LOCATION (City or town) (County) (State) <u>Colmar Manor, Md.</u>
24 FUNERAL DIRECTOR <u>Lee Funeral Home 300 4th St. N.E. Wash. D.C.</u>		25a REC'D BY REGISTRAR <u>MAR 10 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
GM 1/67

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03901

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03899

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admiss on) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>8719-Irvington St.</u>	
3 NAME OF DECEASED (Type or print) <u>Creston B. Mullins</u>		4 DATE OF DEATH <u>March 26 1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12/12/167</u>
9 AGE (In years last birthday) <u>59</u>		10 IF UNDER 1 YEAR Months <u>26</u> Days <u>19</u> Min <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Information Count.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Information Count.</u>	
11 BIRTHPLACE (State or foreign country) <u>Oklahoma</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>James Mullins</u>		14 MOTHER'S MAIDEN NAME <u>Thurora Black</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes. Navy war</u>		16 SOCIAL SECURITY NO. <u>578-09-8637</u>	
17 INFORMANT <u>To Josephine Mullins / 15 year</u>		Address <u>Bethesda, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BURNS - 2nd + 3rd degree - of 90% of body.</u> DUE TO (b) <u>11th rib</u> DUE TO (c) <u>16th rib</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell asleep in chair while smoking cigarette</u>	
20c. TIME OF INJURY Month, Day, Year <u>1230 PM 3/26 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, off ice bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Bethesda Montgomery Md.</u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3/26/67</u>	
		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-30-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Alexandria Natl Cem.</u>		23d. LOCATION (City or town) (County) (State) <u>Alexandria, Virginia</u>	
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REG STRAR <u>MAR 30 1967</u>	
		25b. REG STRAR'S SIGNATURE <u>John Charles Jones</u>	



03902

CERTIFICATE OF DEATH

03900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Res. date before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Georges Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>151</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>ROBERT MURRAY</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>A</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1917</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>49</u> yrs
11. BIRTHPLACE (County & State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Murray</u>		14. MOTHER'S MAIDEN NAME <u>Mary Nelson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Ruth Murray</u>		Address <u>1140 #</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infected with pneumonia</u> <u>1533</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of the sigmoid colon</u> DUE TO (c) <u>1 year</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2 Nov</u> , 19 <u>66</u> , to <u>16 March</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>16 March</u> 19 <u>67</u> , and that death occurred at <u>8:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John Fawcett</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>19 March 67</u>
22c. PHYSICIAN'S NAME (Type) <u>PC BOYDS Md</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>16 March</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Md</u>
24. FUNERAL DIRECTOR <u>Robert J. Murray</u>		ADDRESS	25a. REC'D BY REGISTRAR <u>MAR 23 1967</u>
			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



03903

CERTIFICATE OF DEATH

03901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> c. LENGTH OF STAY IN 'b <i>5 mos 22 days</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Colonial Villa Nursing Home</i>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Washington, D. C.</i> b. COUNTY <i>Washington</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>5519 Nevada Avenue, N. W.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>Georgia</i> First <i>9.</i> Middle <i>Myers</i> Last 4 DATE OF DEATH <i>March 28</i> Month Day Year <i>19 67</i>		5 SEX <i>female</i> 6 COLOR OR RACE <i>white</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8 DATE OF BIRTH <i>June 2, 1876</i> 9. AGE (In years last birthday) <i>90</i> yrs 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i> 11 BIRTHPLACE (County & State, or foreign country) <i>Urichsville, Ohio</i> 12 CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Harper</i> 14. MOTHER'S MAIDEN NAME <i>Mary Barr</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i> 16 SOCIAL SECURITY NO <i>213-54-6419</i> 17. INFORMANT <i>Dorothy G. Mergner</i> Address <i>5519 Nevada Ave., N. W. Washington, D. C.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute heart failure</i> DUE TO (b) <i>Generalized arteriosclerosis</i> stating the underlying cause last. (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>old CVA, diabetes ulcers &amp; cellulitis</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>10-9</i> , 19 <i>66</i> , to <i>3-28</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>1-22-1967</i> , and that death occurred at <i>2:55 P.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>R. H. Sandstrom M.D.</i> 22c. PHYSICIAN'S NAME (Type) <i>R. H. Sandstrom M.D.</i>		22b. DATE SIGNED <i>3-29-67</i> 22d. ADDRESS <i>7701 Carroll Ave Takoma Park, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 23b. DATE THEREOF <i>Mar 30, 1967</i> 23c. NAME OF CEMETERY OR CREMATORY <i>Prospect Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington, D. C.</i>	
24. FUNERAL DIRECTOR <i>John B. Thomas</i> <i>Warner E. Pumphrey, Inc.</i> ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR <i>MAR 31 1967</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	









03905

CERTIFICATE OF DEATH

03903

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. LENGTH OF STAY IN 1b <b>Years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		d. STREET ADDRESS <b>3801 Williams Lane</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3801 Williams Lane</b>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>RICHARD TEMPLEMAN NAYLOR</b>		4 DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Feb. 3, 1878</b>
9 AGE (In years last birthday) <b>89</b> yrs.		10 IF UNDER 1 YEAR Months <b>2</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Banker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <b>Washington, D. C.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13 FATHER'S NAME <b>Henry Naylor</b>		14 MOTHER'S MAIDEN NAME <b>Charlotte Templeman</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b>Unknown</b>	
17 INFORMANT <b>Sister</b>		Address <b>Same as Item 2.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cardiovascular Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>Years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Emphysema</b>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1963</b> to <b>date</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>14 March 1967</b> , and that death occurred at <b>3:30 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>John G. Ball</b>		22b. DATE SIGNED <b>3/20/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN G. BALL</b>		22d. ADDRESS <b>7936 Old Georgetown Rd. Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-22-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAR 28 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03906

CERTIFICATE OF DEATH

03904

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

CASE REVIEWED & DISCLOSED TO MONT. CO. MEDICAL EXAMINER

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN 1b <b>7 hours</b>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		d. STREET ADDRESS <b>419 Reading Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Mary A. Nellinger</b>		4 DATE OF DEATH Month Day Year <b>March 27 1967</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>2-19-1882</b>
9a. AGE (In years last birthday) <b>85 yrs</b>		9. IF UNDER 1 YEAR Months Days Hours Min. <b>27 19 67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Fulmer</b>		14. MOTHER'S MAIDEN NAME <b>? Hargate</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) <b>No --</b>		16. SOCIAL SECURITY NO. <b>213-56-0542</b>	
17. INFORMANT <b>Medical Records</b>		Address <b>Olney, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE MASSIVE</b> DUE TO (b) <b>CEREBRAL ARTERIOSECTOSIS</b> DUE TO (c) <b>HYPER TENSIVE CARDIOVASCULAR DIS.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>INTERVAL BETWEEN ONSET AND DEATH 4 YRS 5-10 YRS</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ASPIRATION PNEUMONITIS - TERMINAL</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>3/27 1967</b> , that (2) (we) last saw the deceased alive on <b>3/27 1967</b> , and that death occurred at <b>12:45 M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Ronald R. Lewis</b>		22b. DATE SIGNED <b>3/27/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>D. R. Lewis, M.D.</b>		22d. ADDRESS <b>Medical Center, Sandy Spring, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-30-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Frederick, Maryland</b>
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAR 30 1967</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03907

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03905

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>16 days</u>		d. STREET ADDRESS <u>903 Baltimore Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frances Gaither Nichols</u>		4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. CO. OR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/7/1869</u>
9. AGE (In years last birthday) <u>97</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
11a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Eugene C. Gaither</u>	
14. MOTHER'S MAIDEN NAME <u>Anderson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No Unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>214-52-3076T</u>		17. INFORMANT <u>Eugene Nichols</u> Address <u>1600 St. Andrews Dr. Arlington, Va.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism -</u> DUE TO (b) <u>Fracture of Right Hip -</u> DUE TO (c) <u>Cardiovascular Disease -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hr.</u> <u>16 days.</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18) <u>Fall at Nursing Home causing Fracture Rt Hip</u>	
20c. TIME OF INJURY Month, Day, Year <u>12:30 am 2/18 1967</u>		20d. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Nursing Home</u>	
20e. (City or town) <u>Rockville</u> (County) <u>Mont.</u> (State) <u>Md.</u>		20f. (City or town) <u>Rockville</u> (County) <u>Mont.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>3/6/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>	
23b. DATE THEREOF <u>3-9-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	
23d. LOCATION (City or Town) <u>Arlington</u> (County) <u>D. C.</u> (State) <u>D. C.</u>		24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u> ADDRESS <u>Gaithersburg</u>	
25a. REC'D BY REG. STRAR <u>MAR 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

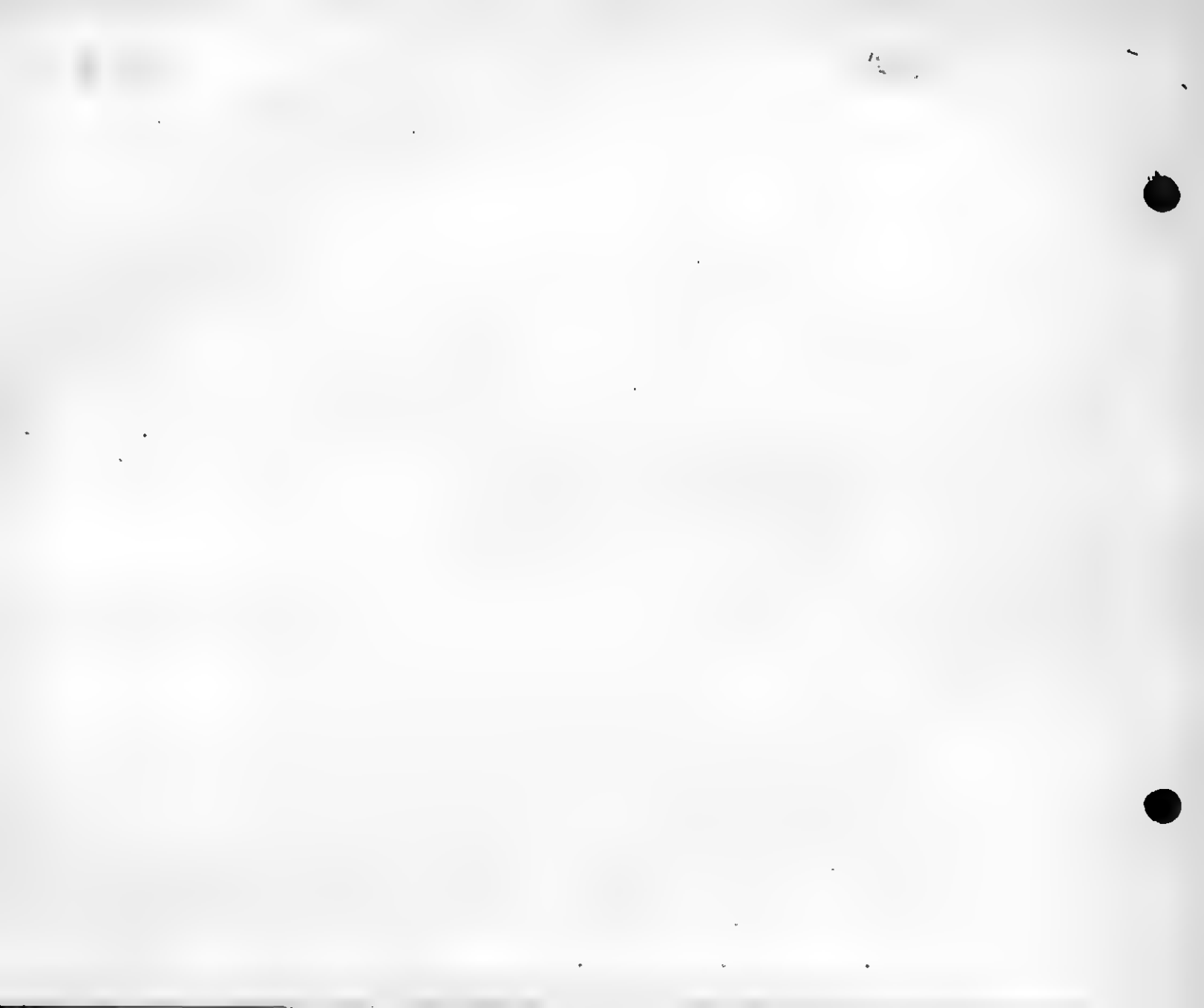
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03908

## CERTIFICATE OF DEATH

03908

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> c. LENGTH OF STAY IN 1b <i>5 days</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	
3. NAME OF DECEASED (Type or print) <i>Mary BLACK Nicholson</i>		4. DATE OF DEATH Month <i>3</i> Day <i>15</i> Year <i>1967</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-14/86</i>
9. AGE (In years last birthday) <i>80</i> yrs.		10. IF UNDER 1 YEAR Months <i>1</i> Days <i>15</i> Hours <i>00</i> Min <i>00</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Paul Black</i>		14. MOTHER'S MAIDEN NAME <i>Juliet Buckley</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No.</i>		16. SOC. A. SECURITY NO. <i>527-03-7636</i>	
17. INFORMANT <i>Mrs. Wm. Black Nicholson</i>		Address <i>Same as above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Thromboses</i> DUE TO <i>Coronary Heart Failure</i> (b) <i>Arteriosclerosis &amp; Coronary Heart Disease &amp; Cong. Heart Failure</i> DUE TO <i>Heart Disease &amp; Cong. Heart Failure</i> (c) <i>Heart Disease &amp; Cong. Heart Failure</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>3-11</i> , 19 <i>67</i> , to <i>3-15</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>3-11</i> , 19 <i>67</i> , and that death occurred at <i>10:00</i> P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>W. T. Joyce</i>		22b. DATE SIGNED <i>3-16-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>W. T. Joyce</i>		22d. ADDRESS <i>4977 Battery Lane, Bethesda, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>3-18-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Rockville Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR <i>MAR 22 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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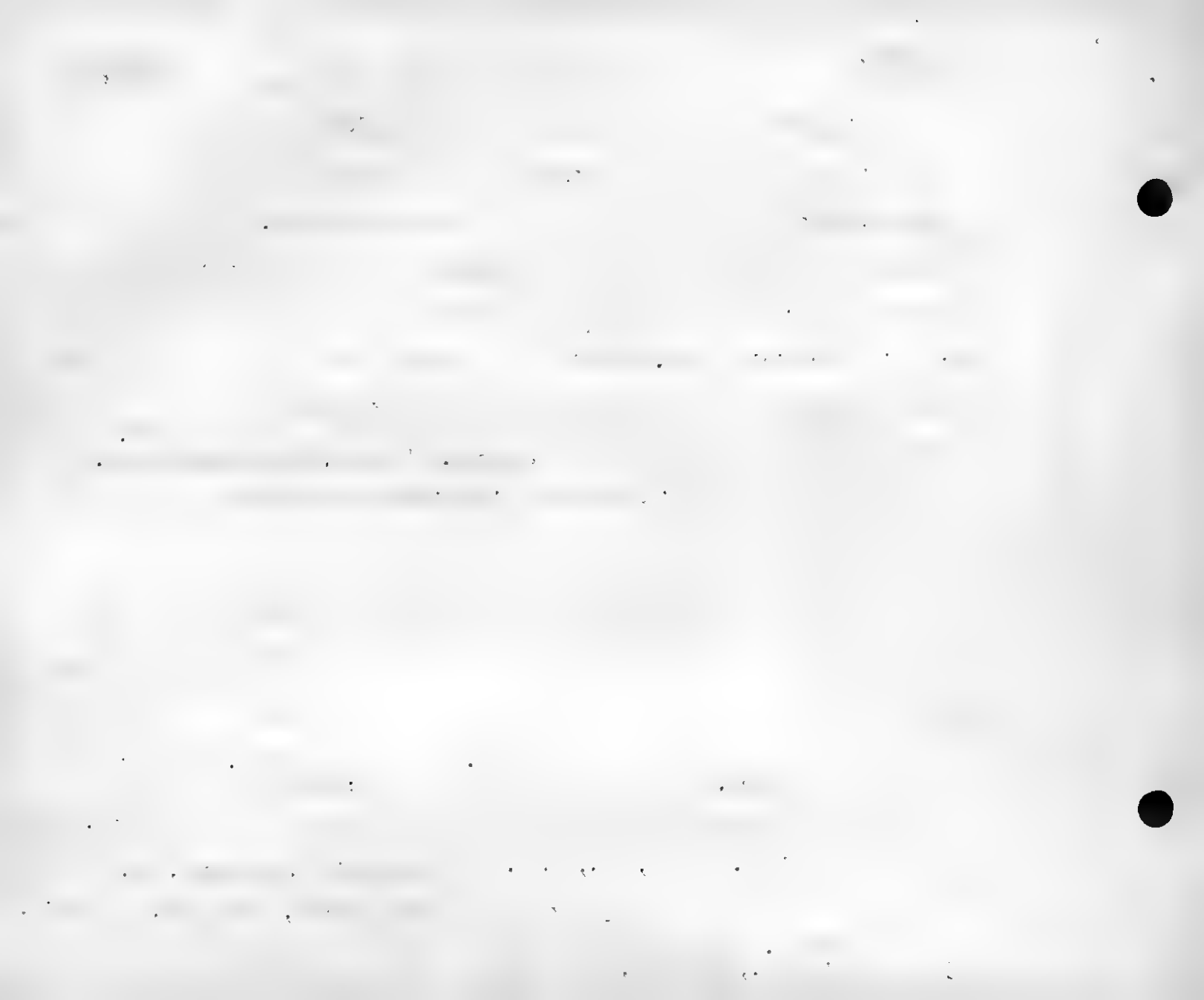
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03909

CERTIFICATE OF DEATH

03907

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Eileen Mary O'ROURKE</b>		4 DATE OF DEATH Month <b>March</b> Day <b>28</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8 May 1916</b>
9. AGE (In years lost birthday) <b>50</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret. red) <b>Accounting Technician</b>		10b. KIND OF BUSINESS IND. STRY <b>Printing Bur. Engraving</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Toledo, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Eiler Nelson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Gizenlenk</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. INFORMANT <b>Waldorf</b>		Address <b>Md.</b> <b>James I. O'Rourke, 1012 Stoddert Ave.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma breast with widespread metastases</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>170X</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>Mar. 17</b> , 19 <b>67</b> , to <b>Mar. 28</b> , 19 <b>67</b> that (we) (we) lost saw the deceased alive on <b>Mar. 28</b> , 19 <b>67</b> , and that death occurred at <b>1:45 PM</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>Francis D. Keenan, Jr.</b>		22b. DATE SIGNED <b>30 Mar. 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Francis D. Keenan, Jr., M. D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Type) <b>Burial-transit</b>		23b. DATE THEREOF <b>3-21-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Golden Gate National Cemetery, San Bruno, Calif.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Funeral Home</b>		25a. REC'D BY REGISTRAR <b>ARK J 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>7557 Wisconsin Ave., Bethesda, Maryland</b>	



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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03910

CERTIFICATE OF DEATH

03908

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>84 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, NIH, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Judith Marie Osenlund</b>		4. DATE OF DEATH Month Day Year <b>March 21 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 October 1946</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	9. AGE (In years last birthday) <b>20</b> Months Days Hours Min
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Karl Osenlund</b>		14. MOTHER'S MAIDEN NAME <b>Marie O'Brien</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Not available</b>	
17. INFORMANT <b>The Medical Records, The Clinical Center, National Institutes of Health, Bethesda, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Staphylococcal Septicemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Pneumonia (bilateral)</b> DUE TO (c) <b>Acute Lymphocytic Leukemia</b>		INTERVAL BETWEEN DEATH AND DEATH <b>28 hours</b> <b>4 Days</b> <b>17 Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Meningeal Leukemia</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>she</b> (this hospital) attended the deceased from <b>27 December 19 66</b> , to <b>21 March 19 67</b> that <b>she</b> (we) last saw the deceased alive on <b>21 March 19 67</b> , and that death occurred at <b>8:45 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Jerry L. Spivak</i>		22b. DATE SIGNED <b>21 March 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jerry L. Spivak, MD.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<b>Burial-transit</b>	<b>3-220-67</b>	<b>Arlington Natl Cem.</b>	<b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAR 27 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



03911

## CERTIFICATE OF DEATH

03909

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1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c LENGTH OF STAY in lb <u>1 hour 32 min</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d STREET ADDRESS <u>4202 Wicomico Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Inf Girl</u> First <u>Overman</u> Middle Last				4 DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 2, 1967</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) yrs <u>2</u> Months <u>1</u> Days <u>32</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>David L. Overman</u>				14. MOTHER'S MAIDEN NAME <u>Carol Colvin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <u>David L. Overman</u> Address <u>Beltsville, Md</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Anoxia</u> 7625 DUE TO (b) <u>Immaturity (20 wks)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						INTERVA. BETWEEN ONSET AND DEATH <u>92 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>2:00 PM</u> , 19 <u>67</u> , to <u>2:40 PM</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>27 Mar 1967</u> , and that death occurred at <u>3:50 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Charles R. Hughes, M.D.</u>				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>3 Mar '67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles R. Hughes M.D.</u>				22d. ADDRESS <u>911 Silver Spring Ave. S.S. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/6/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u> ADDRESS <u>111 Rockville Pike, Rockville, Md.</u>				25a. REC'D BY REGISTRAR <u>Mar 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



03912

## CERTIFICATE OF DEATH

Reg. Dist. No.

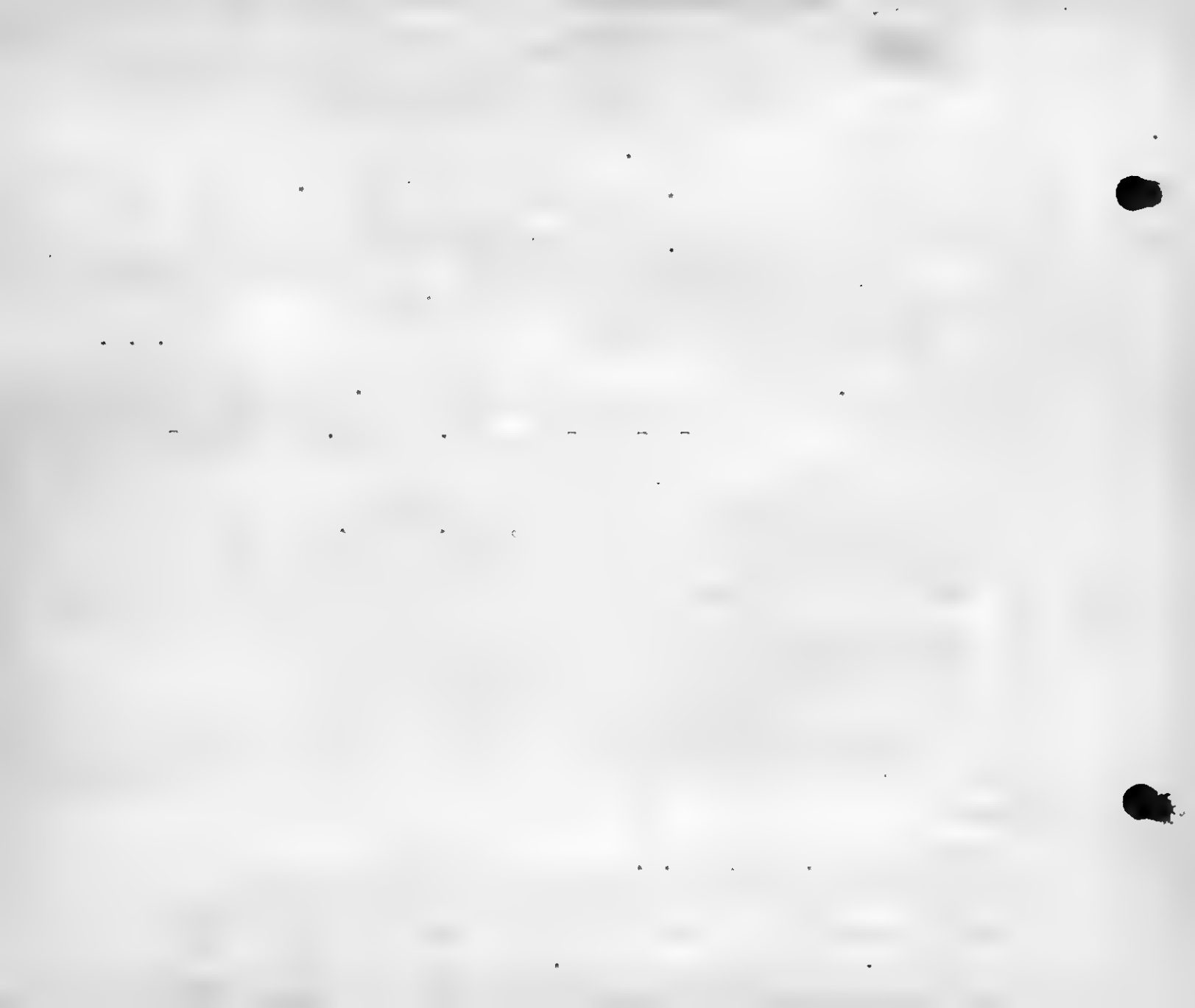
03910

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7609 Marbury Rd.</b>		4. STREET ADDRESS <b>7609 Marbury Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>CARRIE</b> Middle <b>M.</b> Last <b>OXRIEDER</b>		4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 30, 1876</b>
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Judson W. Fuller</b>		14. MOTHER'S MAIDEN NAME <b>Eleanor J. Comstock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>287-44-0241</b>	
17. INFORMANT <b>Mrs. Mona A. Klepinger</b>		Address <b>Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardio-respiratory failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis, gen.; cong. failure</b> DUE TO (c) <b>1 month</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>25 July, 1966</b> to <b>3 March, 1967</b> , that I last saw the deceased alive on <b>2 March, 1967</b> , and that death occurred at <b>6:45A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>[Signature]</i>		ADDRESS (Street, city or town, state) <b>7801 Norfolk Avenue</b>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>JOHN M. WYMAN, M.D.</b>		<b>Bethesda, Maryland 20014</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/7/1967</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Maple Grove</b>	22d. LOCATION (City, town, or county) (State) <b>Granville, Ohio</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Md.</b>	
24a. REGISTERED BY REGISTRAR <b>MAR 10 1967</b>		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, who should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03914

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03912

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville, Md.		c. LENGTH OF STAY IN ID 1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 616 Nelson St.		d. STREET ADDRESS 616 Nelson St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <del>Esperanza</del> Esperanza		First Middle Last Eschoyez de Paolini		4. DATE OF DEATH Month Day Year March 19 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 23 1897	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 6 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Argentina	
13. FATHER'S NAME Carlos Eschoyez		14. MOTHER'S MAIDEN NAME Neurenhousin		12. CITIZEN OF WHAT COUNTRY? Argentina	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Miguel Cascardo	
				Address Rockville, Md. 616 Nelson St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Insufficiency acute - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Cardiovascular Disease - (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED 3/19/67 ACTUAL SIGNATURE John G. Ball M.D. EXAMINER'S NAME (Type) John G. Ball 7936 Old Georgetown Rd. Bethesda, Maryland 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 23b. DATE THEREOF 3/20/67 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill 23d. LOCATION (City, town or county) (State) Prince George's Co. Md. 24. FUNERAL DIRECTOR Tyson Heeler 1371 Rockville Pike Rockville, Md. 25a. REC'D BY REGISTRAR MAR 23 1967 25b. REGISTRAR'S SIGNATURE Charles Judge					



03915

## CERTIFICATE OF DEATH

03913

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Allegheny</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>41. 11 months 10 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>		d. STREET ADDRESS <u>2853 Ontario Road, N. W.</u>	
3 NAME OF DECEASED (Type or print) <u>Edward Taylor Papson</u>		4 DATE OF DEATH Month <u>March</u> Day <u>26</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jan. 20-1891</u>
9. AGE (In years last birthday) <u>76</u> yrs		IF UNDER 1 YEAR Months <u>2</u> Days <u>6</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. GOVERNMENT ACCOUNTANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Howard City, Michigan</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U. S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13 FATHER'S NAME <u>Papson</u>		14. MOTHER'S MAIDEN NAME <u>Edith Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes 1st. W. WAR</u>		16 SOCIAL SECURITY NO <u>579-44-6280</u>	
17 INFORMANT <u>Ralph P. Aten-2853 Ontario Rd. N.W.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <u>4500</u> IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1966</u> to <u>March 1967</u> , that (I) (we) last saw the deceased alive on <u>May 25, 1967</u> , and that death occurred at <u>10 A.M.</u> from causes and on the date stated above.			
22a SIGNATURE <u>Marvin Wadler</u>		22b DATE SIGNED <u>3/21/67</u>	
22c PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>		22d ADDRESS <u>8218 Wisc. Ave. Bethesda, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>3/28/67</u>	<u>Arlington Nat'l Cem.</u>	<u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>The S. Hines Co.</u>		25a REC'D BY REGISTRAR <u>MAR 28 1967</u>	25b REGISTRAR'S SIGNATURE <u>John Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

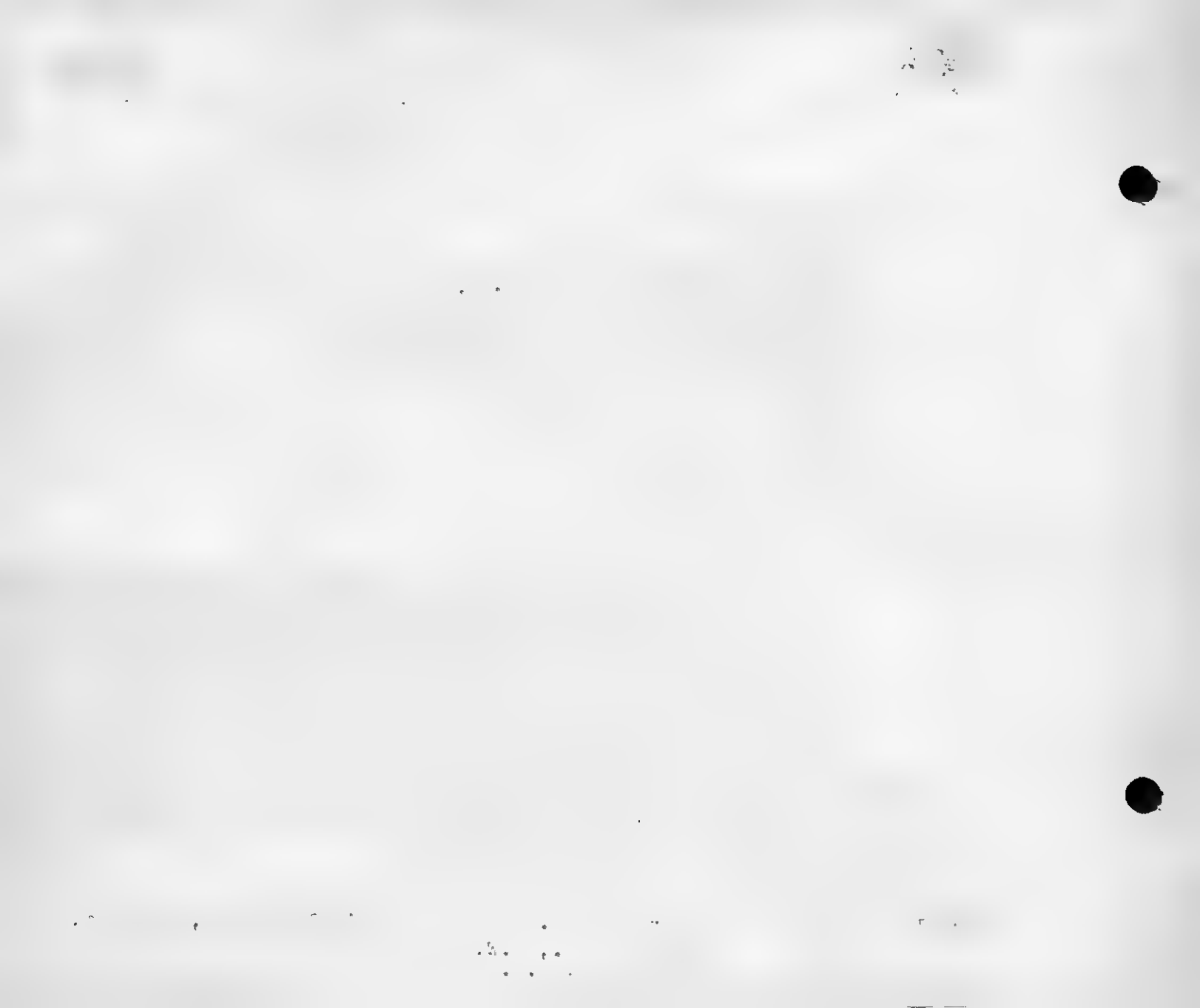
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03916

CERTIFICATE OF DEATH

03914

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmont Heights</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		d. STREET ADDRESS <u>700 60th Place</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Helen L. Parker</u>		4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 7, 1887</u>
9. AGE (In years last birthday) <u>80</u> yrs		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u> IF UNDER 24 HRS: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, if identified) <u>Teacher (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christopher McKinney</u>		14. MOTHER'S MAIDEN NAME <u>Leonora Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>217-52-3381</u>	
17. INFORMANT <u>Donald Parker, Son</u>		Address <u>700 60th Place</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>central arteriosclerosis</u> DUE TO (c) <u>general arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>unknown</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1, 1967</u> to <u>March 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb 27, 1967</u> , and that death occurred at <u>3:55 a.</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Henry G. Hadley</u>		22b. DATE SIGNED <u>Mar 28 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Henry G. Hadley</u>		22d. ADDRESS <u>7601 Andrews Ave SW Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>3/31/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Mem. Park</u>		23d. LOCATION (City, town, or county) (State) <u>highland Park, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Judge</u>		25a. REC'D BY REGISTRAR <u>MARK 31 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Judge</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03917

Item #4 Film #G347 3/2/67

## CERTIFICATE OF DEATH

03915

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>625 W. Lynfield Drive.</u>	
3. NAME OF DECEASED (Type or print) First <u>Rosa</u> Middle <u>L.</u> Last <u>Parker</u>		4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/20/1904</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u>19</u> Days <u>19</u> Hours <u>02</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>John T. George</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Clark</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>578-50-0418</u>	
17. INFORMANT <u>Margaret L. Frazier - daughter</u>		Address <u>same as 15</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> DUE TO (b) <u>Chronic lymphocytic leukemia</u> DUE TO (c) <u>Heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVA. BETWEEN ONSET AND DEATH <u>2-3</u> <u>4 years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic heart disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 9, 1960</u> to <u>May 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 19, 1967</u> , and that death occurred at <u>11:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>G. Bowditch Hunter</u>		22b. DATE SIGNED <u>3/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Bowditch Hunter</u>		22d. ADDRESS <u>60 Edmonston Driv., Rock. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/22/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince George Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Lyn Heeler 1331 Rockville Pike</u>		25a. REC'D BY REGISTRAR <u>MAR 23 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03918

03916

1. PLACE OF DEATH a. COUNTY: <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: <b>MD</b> b. COUNTY: <b>MONT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BURTONSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BURTONSVILLE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>OLD COLUMBIA PIKE</b>		d. STREET ADDRESS <b>OLD COLUMBIA PIKE</b>	
3. NAME OF DECEASED (Type or print) First: <b>ANNIE</b> Middle: <b>ELIZABETH</b> Last: <b>PARSLEY</b>		4. DATE OF DEATH Month: <b>MARCH</b> Day: <b>26</b> Year: <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 25 1950</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>HOWARD Co - MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FRANK WILSON</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE A JAMIESON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-56-5782</b>	
17. INFORMANT <b>MISS CLARA CARR - Spouse</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage - large intestine</b> 1531 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Carcinoma splenic flexure</b> DUE TO (c) <b>Hemorrhagic shock &amp; anemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>2-3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>malnutrition - secondary to above</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour: <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>NOV 30, 1964</b> to <b>MAY 26, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 26, 1967</b> , and that death occurred at <b>3:15 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>John R. Spencer</b>		22b. DATE SIGNED <b>3-26-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>BURTONSVILLE, MD</b>		22d. ADDRESS <b>BURTONSVILLE, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>March 26, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Airy Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Burtonsville Montgomery Md.</b>
24. FUNERAL DIRECTOR <b>Robert R. Spencer</b>		25a. REC'D BY REGISTRAR <b>APR 5 1967</b>	
ADDRESS <b>Burtonsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03919

03917

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. &amp; Hospital</u>		d. STREET ADDRESS <u>1319 Merrimac Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>Jacob Pasis</u>		4. DATE OF DEATH Month <u>3</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OF RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 22 - 01 65</u> yrs
9. AGE (In years lost birthday) <u>65</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cab driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TAXI</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>ABRAHAM L. PASIS</u>		14. MOTHER'S MAIDEN NAME <u>ANNA KURSANO</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-03-8518</u>	
17. INFORMANT <u>Wife - Mrs. Fannie Pasis</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart disease</u> DUE TO (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u>Diabetes, Emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/12</u> , 1967, to <u>3/3</u> , 1967, that (I) (we) last saw the deceased alive on <u>2/12</u> , 1967, and that death occurred at <u>7:50</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Maurice Frank m.D</u>		22b. DATE SIGNED <u>3/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Maurice Frank m.D</u>		22d. ADDRESS <u>1330 N.H. Ave. N.W. 20036</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-6-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>HYATTSVILLE MD</u>
24. FUNERAL DIRECTOR <u>Holberg Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>4217-95th N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAR 7 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1880  
1881  
1882



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with ~~24~~ hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03920

CERTIFICATE OF DEATH

03918

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY COUNTY MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring MD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>2601 Madison Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>Flora R. Percock</u>				4. DATE OF DEATH Month <u>3</u> Day <u>11</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>CAU</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/26/1902</u>	
9. AGE (In years, last birthday) <u>79</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Buyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>		11. BIRTHPLACE (County & State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John Myer</u>			
14. MOTHER'S MAIDEN NAME <u>Ester (Unknown)</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>			
16. SOCIAL SECURITY NO. <u>236-07-9860</u>				17. INFORMANT <u>Mrs. Sophie R. Berman</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Conjunctive Heart failure Pulmonary Edema</u> DUE TO (b) <u>Cardiovascular Disease, Renal Shutdown</u> DUE TO (c) <u>Chronic Renal Disease, Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>Approx 16 hrs</u> <u>Chronic</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes, GI Bleeding</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>				20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Sub</u>			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>67</u> , to <u>Mar 11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Mar 11</u> , 19 <u>67</u> , and that death occurred at <u>1:30 P.</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>R. Bufalino, M.D.</u>				22b. DATE SIGNED <u>Mar 11, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Russell C. Bufalino M.D.</u>				22d. ADDRESS <u>1429 University Blvd W Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Inter-burial</u>		23b. DATE THEREOF <u>March 14, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ba'ni Jacob Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Charlton, West Virginia</u>	
24a. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				24b. ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>			
25a. REC'D BY REGISTRAR <u>Charles Judge</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
03921					03919					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY Montgomery MARYLAND					a. STATE Massachusetts b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mattapan					
c. LENGTH OF STAY IN 1b 90 Minutes					d. STREET ADDRESS 25 Old Morton Street					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH		Month Day Year		
Richard Wayne Pogue					March 21 1967					
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	18 December 1912		54 yrs.	Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			10b. KIND OF BUSINESS OR INDUSTRY Medical Supplies		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Roscoe O. Pogue					14. MOTHER'S MAIDEN NAME Eva B. Thrope					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. 1944-1946 493-36-0665		17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> + ~ ~ ~ ~ ~ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Cardio Vascular Disease.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs.</u> <u>years.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>John G. Ball</u>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED <u>3/21/67</u>							
EXAMINER'S NAME (Type) John G. Ball, MD.			Address (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3/24/67		23c. NAME OF CEMETERY OR CREMATORY Hampton National Cem.		23d. LOCATION (City, town or county) (State) Hampton, Virginia			
24. FUNERAL DIRECTOR <u>Arnold S. Sauer</u>					ADDRESS Falls Church F. H. 1102 W. Broad St. Falls Church, Va.		25a. REC'D BY REGISTRAR DATE <u>MAR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>W. Charles Judge</u>	





03922

CERTIFICATE OF DEATH

03920

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CLEARED BY MEDICAL EXAMINER

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>Hours</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>1 MANCHESTER PLACE #302</u>	
3 NAME OF DECEASED (Type or print) <u>WILBUR David PRICE</u>		4 DATE OF DEATH Month <u>MARCH</u> Day <u>2</u> Year <u>19 67</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8-28-21</u>
9 AGE (In years last birthday) <u>45</u> yrs		10 IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u> Hours <u>24</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Wayne County, N. C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David W. Price</u>		14 MOTHER'S MAIDEN NAME <u>Cynthia Godwin</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWII</u>		16 SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Mrs. Violet Price</u>		Address <u>19608 Fenbrook Drive Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <u>331X</u> IMMEDIATE CAUSE (a) <u>Intraventricular hemorrhage</u> DUE TO (b) <u>Essential hypertension</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Fatty cirrhosis of liver</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>63</u> , to <u>3/2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/2</u> , 19 <u>67</u> , and that death occurred at <u>9:30 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Raymond T. Benack</u> M.D.		22b. DATE SIGNED <u>3/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Raymond T. Benack MD</u>		22d. ADDRESS <u>4115 Cole Drive Wheaton Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>	23b. DATE THEREOF <u>March 4, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Greensboro, North Carolina</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u>		25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
20 M 1/8

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
03913					CERTIFICATE OF DEATH					03911				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>17 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>					d. STREET ADDRESS <u>8003-Rentbury Dr.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillian Newell Fuderer</u>					4. DATE OF DEATH Month Day Year <u>March 10 1967</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/14/09</u>		9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Personnel Supervisor Govt.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Govt.</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Louisiana</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Carroll Harper Newell</u>					14. MOTHER'S MAIDEN NAME <u>Katherine Wade Norton</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>- -</u>		17. INFORMANT Address <u>Mrs. Wm. H. Clark, 1332 1/2 E. 16th St., Baltimore, Md.</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC BREAST CARCINOMA</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>5 MONTHS</u>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from <u>MAR 1</u> , 19 <u>67</u> to <u>MAR 10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>MAR. 10</u> , 19 <u>67</u> , and that death occurred at <u>10:2</u> M, from causes and on the date stated above.														
22a. SIGNATURE <u>Robert C. Daddario</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/11/67</u>							
22c. PHYSICIAN'S NAME (Type) <u>ROBERT C. DADDARIO</u>					22d. ADDRESS <u>5413 CEDAR LANE, BETHESDA</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>3/13/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>						
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc. Washington, D.C.</u>					25a. RECD BY REGISTRAR DATE <u>MAR 14 1967</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03923

## CERTIFICATE OF DEATH

03921

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover</u>	
c. LENGTH OF STAY IN 1b <u>10 days</u>		d. STREET ADDRESS <u>7410 C Landover Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ESTHER M. QUINN</u>		4. DATE OF DEATH <u>MARCH 12 19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/2/13</u>
9. AGE (In years lost birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR: Months <u>12</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Ont. Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>Canada</u>	
13. FATHER'S NAME <u>David Robert Quigge</u>		14. MOTHER'S MAIDEN NAME <u>Esther Sandford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Vincent J Quinn</u>		Address <u>Landover, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>330X</u> IMMEDIATE CAUSE (a) <u>Intracerebral and subarachnoid hemorrhage</u> DUE TO (b) <u>due to ruptured Berry aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/28</u> , 19 <u>67</u> , to <u>3/12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/12</u> , 19 <u>67</u> , and that death occurred at <u>4:35p</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert H. Macon</u>		22b. DATE SIGNED <u>3/12/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert Macon, M.D.</u>		22d. ADDRESS <u>809 Viers Mill Road, Rockville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 15, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington D. C.</u>	
24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u>		25a. REC'D BY REGISTRAR <u>MAR 16 1967</u>	
ADDRESS <u>Hyattsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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